

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03400

3465

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pt. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7263-L-Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Colbert Addison</u>		4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-15-1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Loage Addison</u>		14. MOTHER'S MAIDEN NAME <u>Louise Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Blanche Castle: Laurel, Md.</u>	
17. INFORMANT Address <u>Blanche Castle: Laurel, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hy pertensive cardiovascular disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sensitivity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-20-59</u>		22b. DATE THEREOF <u>3-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Queen's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Kirk Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>467 N of NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03401

Reg. Dist. No.

3418

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tokoma Park, Md	c. LENGTH OF STAY IN 1b 5 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Tokoma Park, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1113 Kingwood Drive		d. STREET ADDRESS 1113 Kingwood Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John Joseph Allegretto		4. DATE OF DEATH March 4, 19 59-	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 25, 1897
		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Delaware
		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Allegretto		14. MOTHER'S MAIDEN NAME Florence ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I and II		16. SOCIAL SECURITY NO. 579-10-2681	17. INFORMANT Rose M Allegretto
		Address Tokoma Park, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 5, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 9, 1959	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Miller, 254 Carroll St NW Wash. D.C.		24a. REC'D BY REGISTRAR DATE MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kane

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03402

Reg. Dist. No.

3419

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 16 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
3. NAME OF DECEASED (Type or print) George		f. STREET ADDRESS 5030 38th Avenue	
4. DATE OF DEATH March 23, 19 59		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-33
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police officer		10b. KIND OF BUSINESS OR INDUSTRY Town Police Force	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Allen		14. MOTHER'S MAIDEN NAME Hester Ballard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-44-4211	
17. INFORMANT Betty A. Allen; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression 815X DUE TO Subdural hemorrhage Conditions, if any, which gave rise to immediate cause (b) Subdural hemorrhage (c) Subdural hemorrhage causing the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operator of a motorcycle in collision with an automobile.			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of a motorcycle in collision with an automobile.	
20c. TIME OF INJURY Month, Day, Year 4. 3-22- 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Palmer Park (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John D. Maloney		DATE SIGNED March 23, 1959	
EXAMINER'S NAME (Type) John Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR MAR 26 '59 DATE	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thant	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
HEALTH DEPT.

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Usual Residence: [illegible]
7. Cause of Death: [illegible]
8. Manner of Death: [illegible]
9. Date of Death: [illegible]
10. Time of Death: [illegible]
11. Place of Death: [illegible]
12. Signature of Medical Examiner: [illegible]
13. Signature of Coroner: [illegible]
14. Signature of Registrar: [illegible]
15. Signature of [illegible]: [illegible]
16. Signature of [illegible]: [illegible]
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99. Signature of [illegible]: [illegible]
100. Signature of [illegible]: [illegible]

3417

CERTIFICATE OF DEATH

03403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3712-36th Street				d. STREET ADDRESS 13712-36th St.			
3. NAME OF DECEASED (Type or print) First Middle Last Francis M. Bassett				4. DATE OF DEATH 3 - 4 - 1959			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-26-1870	
9. AGE (In years last birthday) 89		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Hardware		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lincolville, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Amos Bassett			
14. MOTHER'S MAIDEN NAME Matilda Matson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. 127-05-1041				17. INFORMANT Mrs Helen B. Bower, 3712-36th St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure. 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 23, 1959, to March 4, 1959, that I last saw the deceased alive on Feb. 28, 1959, and that death occurred at 10:17 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert F. Dilworth M.D.				ADDRESS (Street, city or town, state) 1835 K St., N.W., Washington, DC			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/7/59		22c. NAME OF CEMETERY OR CREMATORY Granville Center		22d. LOCATION (City, town, or county) (State) Granville Center, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				ADDRESS Mt. Rainier Md		24a. REC'D BY REGISTRAR DATE MAR 9 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3420

CERTIFICATE OF DEATH

03404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Hgts.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Capitol Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6148 Shady Side Ave</u>		d. STREET ADDRESS <u>6148 Shady Side Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE W BEALL</u>		4. DATE OF DEATH Month Day Year <u>March 27 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE W. BEALL</u>		14. MOTHER'S MAIDEN NAME <u>HAVERNIA. Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary V. Beall</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Atherosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary</u> DUE TO (c) <u>Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 4, 1958</u> , to <u>March 27, 1959</u> , that I last saw the deceased alive on <u>March 19, 1959</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>3/27/59</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		<u>Capitol Hgts Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>See Funeral Home INC</u> ADDRESS <u>300-4 St</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3470

CERTIFICATE OF DEATH

03405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr. Geos County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr. Geos Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brightseat (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Brightseat (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brightseat Rd Landover, Md.</u>		d. STREET ADDRESS <u>Brightseat Rd Landover Md.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Owens</u> Middle <u>Beane</u> Last		4. DATE OF DEATH <u>March</u> Month <u>27</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY (Own) <u>Tobacco Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James E Beane</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Brady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>x</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Roger O Beane Landover Md RDP</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsons Syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 11, 1949</u> to <u>March 27, 1959</u> , that I last saw the deceased alive on <u>March 26, 1959</u> , and that death occurred at <u>12:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Suit Ritchie</u> M.D.		ADDRESS (Street, city or town, state) <u>7005 Ritchie Road SE</u> DATE SIGNED <u>3/27/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. W. Suit Ritchie</u>		<u>Wash 27 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Foran</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In a vacant lot at 28th and Keating Sts			d. STREET ADDRESS 5858 28th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Jefferson First Nicholas Middle Becker Last			4. DATE OF DEATH Month March Day 23 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1898		9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (U.S. Gov't.)		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Harry William Becker			14. MOTHER'S MAIDEN NAME Heineman Elizabeth A. Heneman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 577506246		17. INFORMANT R. Robert B. Becker Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 24, 1959	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St., N.W.		ADDRESS Washington 9, D.C.		24a. REC'D BY REGISTRAR March 26 '59	
				24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 03407											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				c. LENGTH OF STAY IN 1b 3 1/2 Mos.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Bladensburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4102 46th Place						d. STREET ADDRESS 4102 46th Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Andrew Blunt						4. DATE OF DEATH March 3, 19 59					
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1951		9. AGE (in years last birthday) 7 7/8		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Navy Yard		11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Ida Tyson; same address as #2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral compression											
9040 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subdural hemorrhage											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Perforated stomach ulcer											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3-3- p. m. 19 59				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Bladensburg - Pr. Geo. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John T. Maloney						DATE SIGNED March 4, 1959					
EXAMINER'S NAME (Type) John T. Maloney, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3-9-59		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015-25 NE.						24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Rhines			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
HEALTH DEPT

DEPT

DATE OF DEATH

PLACE OF DEATH

RESIDENCE OF DECEASED

AGE OF DECEASED

SEX

RACE

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

ON 1922: same as above

General impression

General impression



2-3-2

1000

DATE OF EXAMINATION

DATE OF EXAMINATION

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DATE OF EXAMINATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03408

3422

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Dead on arrival		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights 36	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 827 58th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Theodore William Boswell			4. DATE OF DEATH Month Day Year March 25, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 February 1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) District of Columbia U. S. A.	
13. FATHER'S NAME William Boswell			14. MOTHER'S MAIDEN NAME Louisa TANNONX Tennyson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W. 1 and 11		16. SOCIAL SECURITY NO. 11		17. INFORMANT Address Alfred Earl Boswell, same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 25, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co Inc, Wash, D.C.		24a. REC'D BY REGISTRAR MAR 30 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		YEAR	
OCCUPATION									
EDUCATION									
MARRIAGE									
PREVIOUS ILLNESS									
CAUSE OF DEATH									
MANNER OF DEATH									
SIGNATURE OF MEDICAL EXAMINER									
DATE									

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, & 17, Film G241, 4/13/59, fcy

03409

3472

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Bn Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>16 Mt. Rainier, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eleven Cedars Rest Home</i>		d. STREET ADDRESS <i>3602 Shepherd st</i>	
3. NAME OF DECEASED (Type or print) <i>SARAH First ESTELLE Middle BOURNE Last</i>		4. DATE OF DEATH <i>MAR 3</i> Day Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1883.</i>
9. AGE (In years last birthday) <i>75.85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government Clerk</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>George William Chase</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>WWI</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>A.</i> Address <i>Mrs Marie M Read Hyattsville Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Respiratory Failure</i> 334X DUE TO <i>Adv Cerebral Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Arteriosclerosis</i> DUE TO (c) <i>General Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 1955</i> to <i>Mar 3 1959</i> , that I last saw the deceased alive on <i>Mar 3 1959</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. C. Etienne</i> M.D.		ADDRESS (Street, city or town, state) <i>4713 - Browning Rd College Park, Md.</i> DATE SIGNED <i>3/4/59</i>	
PHYSICIAN'S NAME (Type) <i>W. C. ETIENNE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 6, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Maryland.</i>	
24a. REC'D BY REGISTRAR <i>DATE MAR 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT RESIDENCE

TEMPORARY RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

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DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

NAME OF CHILD

DATE OF BIRTH OF CHILD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3423 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03410

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jeffrey Paul Brackna		4. DATE OF DEATH Month Mar. Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1958
9. AGE (In years last birthday) yrs. 11		10. IF UNDER 1 YEAR Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Takoma Park, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME a. Albert Brackna		14. MOTHER'S MAIDEN NAME Eleanor M. Wyte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive subarachnoid hemorrhage 9040 DUE TO Conditions, if any, which gave rise to immediate cause (b) Laceration of superior cerebellar plexus (c) Fracture of left occipital bone DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home March 10 & 15, 1959 (Grandmother's)	
20c. TIME OF INJURY Month, Day, Year Hour 3:30 p.m. 3-15- 1959	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Carrollton Pr. Geo. Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Nalley's Funeral Home Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

2075/324XV5-nc.

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3424 CERTIFICATE OF DEATH

03411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 1/2 Hr. d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park d. STREET ADDRESS 4810 Lakeland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Brooks		4. DATE OF DEATH Month Mar. Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 4 Months 30 Days 4 Hours 30 Min.
13. FATHER'S NAME George Franklin Brooks		14. MOTHER'S MAIDEN NAME Jeanette Marie Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Parents, Above Address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Permativity (1st) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar. 7, 1959 , to Mar. 7, 1959 , that I last saw the deceased alive on Mar. 7, 1959 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) College Park, Md. DATE SIGNED 3/11/59			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		PHYSICIAN'S NAME (Type) Thomas A. Christensen M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 3/14/59	22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr. Administrator		24a. REC'D BY REGISTRAR DATE MAR 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14 Film G240 3-30-59 et

3425

CERTIFICATE OF DEATH

03412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN IB 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			
3. NAME OF DECEASED (Type or print) Bernard				4. DATE OF DEATH Month March Day 19 Year 19 59			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Nov. 1905	
9. AGE (In years lost birthday) yrs. 53		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) United States				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Charles Brooks				14. MOTHER'S MAIDEN NAME Sarah Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Alice Wife Address Same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pressure on L.A.A. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 14 , 19 59 to March 19 , 19 59 , that I last saw the deceased alive on March 19 , 19 59 , and that death occurred at 2:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert Roth M.D.				ADDRESS (Street, city or town, state) Brandywine Md			
PHYSICIAN'S NAME (Type) Dr. Albert Roth, Md.				DATE SIGNED 3/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-59		22c. NAME OF CEMETERY OR CREMATORY Gibbons		22d. LOCATION (City, town, or county) (State) Brandywine Md	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle R. Collins ADDRESS 4339 Hunt Pl, NK				24a. REC'D BY REGISTRAR DATE MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

WILLIAM BROWN

WILLIAM BROWN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3473

CERTIFICATE OF DEATH

03413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TEMPLE HILLS c. LENGTH OF STAY IN 1b 7 1/2 YRS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5705 2ND STREET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington (Temple Hills) c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) Washington (Temple Hills) d. STREET ADDRESS 5705 2nd Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Herbert Last Burbage		4. DATE OF DEATH Month March Day 9 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 14, 1908
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer	11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George H. Burbage	
14. MOTHER'S MAIDEN NAME Louise Jefferies		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/58 , 19____, to 3/9/59 , 19____, that I last saw the deceased alive on 3/9/59 , 19____, and that death occurred on 10/408 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence Phillips		ADDRESS (Street, city or town, state) 4698 Rustie Ave SE	
PHYSICIAN'S NAME (Type) Lawrence Phillips, M. D.		DATE SIGNED 3/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Frederick Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		ADDRESS Cedar 577 11th St SE	
24a. REC'D BY REGISTRAR MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03414

Reg. Dist. No.

3426

Item 7 FilmG240 4-2-59 et

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vista		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Butler Last Butler			4. DATE OF DEATH Month March Day 20 Year 19 59		
5. SEX Male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1900		9. AGE (In years (yr) birth day) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John A. Butler			14. MOTHER'S MAIDEN NAME Annie Mitchell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Marie Richardson Address Gettysburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 20, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-59		22c. NAME OF CEMETERY OR CREMATORY Mount View	
				22d. LOCATION (City, town, or county) (State) Emmettsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.			24a. REC'D BY REGISTRAR MAR 26 '59		
ADDRESS 3015 12th St., N. E.			24b. REGISTRAR'S SIGNATURE Arthur S. House		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park-Hyattsville	
c. LENGTH OF STAY IN 1b 15 days		d. STREET ADDRESS 7900 Greenleaf Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eula Mae Caldwell		4. DATE OF DEATH March 31 19 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-1910
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist.		12. KIND OF BUSINESS OR INDUSTRY D.C. Government	
13. BIRTHPLACE (State or foreign country) Alabama		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Frank Stewart		16. MOTHER'S MAIDEN NAME Delphine Clark	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. Hospital Records and John R. Caldwell.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) 3rd degree burns of 70 % of body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Pajamas caught fire by some unknown means.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 10.15 p.m. 3-16-59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Palmer Park (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 31, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) Colmar Manor (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gaschi Sons		24a. REC'D BY REGISTRAR APR 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Fouse			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

052-1-25

2 4 2

Figure 1

200 21 1

3428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 44			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 500 Main Street			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle S. Calhoun Last				4. DATE OF DEATH Month March Day 17 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1881	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Sigman				14. MOTHER'S MAIDEN NAME Edith Canett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) —		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cordis 10 yr 260x DUE TO UG senile degenerative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerotic Arteries 20 DUE TO Sclerotic Arteries 25 (c) 10 in situ - Mollities PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/6, 1955 to 3/17, 1959, that I last saw the deceased alive on 3/17, 1959, and that death occurred at 1:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. M. Warren M.D. Laurel 3-18-59 PHYSICIAN'S NAME (Type) J. M. WARREN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/59		22c. NAME OF CEMETERY OR CREMATORY Allegheny Cem.		22d. LOCATION (City, town, or county) (State) Pittsburgh Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Hamilton, Laurel Md				24a. REC'D BY REGISTRAR DATE MAR 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Reg. No. 100

<p>1. NAME OF DECEASED <i>Charles J. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>March 15, 1893</i></p>	
<p>5. PLACE OF BIRTH <i>Worcester, Mass.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10, 1915</i></p>	
<p>9. NAME OF SPOUSE <i>Elizabeth A. Smith</i></p>		<p>10. DATE OF DEATH <i>April 10, 1938</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. W. Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. SIGNATURE OF DECEASED <i>Charles J. Smith</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03417

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY in lb 35 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 321 Gorman Avenue		d. STREET ADDRESS 985 Jefferson Boulevard	
3. NAME OF DECEASED (Type or print) Henry Joseph Carroll		4. DATE OF DEATH Month March Day 13 Year 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-03
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Racing official		10b. KIND OF BUSINESS OR INDUSTRY Racing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Denial Carroll		14. MOTHER'S MAIDEN NAME Daisy Downey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-4184	
17. INFORMANT Hollis L. Carroll; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) stolting the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED March 13, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-16-59	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hag. Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03418

3474

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Westchester ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB			c. LENGTH OF STAY IN 1b 4 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Rochelle 69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews, Andrews AFB				d. STREET ADDRESS 56 Rockdale Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Anthony Joseph Cerreta				4. DATE OF DEATH Month Day Year March 13 1959			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 August 1931		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James S Cerreta				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1959 120-26-5555		17. INFORMANT Official Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Metastasis 178x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terato carcinoma of testicle DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 Months 9 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 March, 1959, to 13 March, 1959, that I last saw the deceased alive on 13 March, 1959, and that death occurred at 1:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF Hospital Andrews 13 Mar 59 ACTUAL SIGNATURE Richard J. Salina M.D. PHYSICIAN'S NAME (Type) RICHARD J SALINA CAPT USAF (MC) Andrews AFB, Wash 25 D C							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MAR. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) New Rochelle, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi RINALDI FUNERAL HOME, 816 H St., N.E., Wash, D.C.				24a. REC'D BY REGISTRAR DATE MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. 201-1-14

1. PLACE OF BIRTH A. COUNTY B. CITY OR TOWN		2. PLACE OF DEATH A. COUNTY B. CITY OR TOWN	
3. SEX A. MALE B. FEMALE		4. AGE A. YEARS B. MONTHS C. DAYS	
5. OCCUPATION		6. CAUSE OF DEATH A. DISEASE B. INJURY C. POISONING D. OTHER	
7. DATE OF DEATH A. MONTH B. DAY C. YEAR		8. TIME OF DEATH A. HOUR B. MINUTE C. SECOND	
9. SIGNATURE OF DECEASED		10. SIGNATURE OF WITNESS	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CLERK	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF SHERIFF	
15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY	
17. SIGNATURE OF DISTRICT ATTORNEY		18. SIGNATURE OF COUNTY CLERK	
19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF VILLAGE CLERK	
21. SIGNATURE OF POST OFFICE CLERK		22. SIGNATURE OF SCHOOL CLERK	
23. SIGNATURE OF CHURCH CLERK		24. SIGNATURE OF OTHER CLERK	
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TO BE FILLED BY THE CLERK OF THE DISTRICT COURT OF BALTIMORE

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESS

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF TOWNSHIP CLERK

20. SIGNATURE OF VILLAGE CLERK

21. SIGNATURE OF POST OFFICE CLERK

22. SIGNATURE OF SCHOOL CLERK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3430

CERTIFICATE OF DEATH

Reg. Dist. No.

03419

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>30 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>2913 Country Club Rd.</u>							
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u></u> Last <u>Clarke</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 11, 1941</u>	
9. AGE (In years last birthday) <u>17 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Raymond McGarvey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL HEMORRHAGE</u> <u>642.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CRISIS</u> DUE TO (c) <u>ECLAMPSIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/9</u> , 19 <u>59</u> , to <u>3/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/10</u> , 19 <u>59</u> , and that death occurred at <u>1:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Greco</u> M.D.				ADDRESS (Street, city or town, state) <u>6202 Agar Rd. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. William R. Greco., Md</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc. 317 Penn Ave & E</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

2302

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CERTIFICATE OF DEATH

Reg. Dist. No.

03420

3475

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| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST HGTS.</u> | | | | c. LENGTH OF STAY IN lb <u>4 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 SACHEM DRIVE</u> | | | | d. STREET ADDRESS <u>205 SACHEM DRIVE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>PHILIP</u> Middle <u>COCIMANO</u> Last <u>COCIMANO</u> | | | | 4. DATE OF DEATH Month <u>MARCH</u> Day <u>4TH</u> Year <u>1959</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>AUG. 17TH 1882</u> | |
| 9. AGE (In years lost birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. | | IF UNDER 24 HRS. Hours <u>76</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> | | 11. BIRTHPLACE (State or foreign country) <u>ITALY</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>ROSALINO COCIMANO</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET MISSANA</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>577-48-2816</u> | | 17. INFORMANT Address <u>HELEN COCIMANO 205 SACHEM DRIVE SE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cachixia</u>
<u>162.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Corcinomatosis</u>
DUE TO (c) <u>Bronchogenic Carcinoma Right Lung</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension - Arteriosclerosis</u>
INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
<u>3 months</u>
<u>9 months</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>57</u> , to <u>3-4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-3</u> , 19 <u>59</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John J. Cabaraco M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>3801 Guilford Rd S.E.</u> | | | |
| DATE SIGNED <u>Wash. 20 D.C.</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>John J. Cabaraco, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/9/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington Dc</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers & Son</u> | | | | ADDRESS <u>517 11th St S.E.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03421

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. STREET ADDRESS Route 1, Box 295 | |
| 3. NAME OF DECEASED (Type or print) John Howard Collins | | 4. DATE OF DEATH March 29 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-8-1912 |
| 9. AGE (In years last birthday) 46 yrs. | | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian | | 10b. KIND OF BUSINESS OR INDUSTRY Food and Drug Adm. | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Collins | | 14. MOTHER'S MAIDEN NAME Stella Becht | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Christine Collins; same address as # 2. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure
4341 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pending
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type or print) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED March 30, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation | | 22b. DATE THEREOF 4/1/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Worthington | | 22d. LOCATION (City, town, or county) (State) Worthington Ohio | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | 24. REC'D BY REGISTRAR APR 2 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hane | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - ALBANY, N.Y.

| | | | |
|------------------------------------------------------|--|------------------------------------------------------|--|
| <p>NAME OF DECEASED: <u>JOHN J. BROWN</u></p> | | <p>DATE OF DEATH: <u>1917</u></p> | |
| <p>AGE: <u>45</u></p> | | <p>SEX: <u>Male</u></p> | |
| <p>RESIDENCE: <u>123 Main St., New York City</u></p> | | <p>OCCUPATION: <u>Teacher</u></p> | |
| <p>CAUSE OF DEATH: <u>Heart Disease</u></p> | | <p>IMMEDIATE CAUSE: <u>Myocardial Infarction</u></p> | |
| <p>DATE OF BIRTH: <u>1872</u></p> | | <p>PLACE OF BIRTH: <u>New York City</u></p> | |
| <p>EDUCATION: <u>High School</u></p> | | <p>RELIGION: <u>Catholic</u></p> | |
| <p>PREVIOUS ILLNESS: <u>None</u></p> | | <p>PREVIOUS SURGERY: <u>None</u></p> | |
| <p>DATE OF EXAMINATION: <u>1917</u></p> | | <p>PLACE OF EXAMINATION: <u>New York City</u></p> | |
| <p>SIGNATURE OF EXAMINER: <u>[Signature]</u></p> | | <p>DATE: <u>1917</u></p> | |

3476
CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY P. GEO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 3 Box 302 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOSEPH EDWARD CONRAD | | 4. DATE OF DEATH MAR. 30 1959 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 8, 1920 |
| 9. AGE (In years last birthday) 38 yrs. | | IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DELIVERY-MAN | | 10b. KIND OF BUSINESS OR INDUSTRY NATIONAL BISCUIT CO. | |
| 11. BIRTHPLACE (State or foreign country) D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM HENRY CONRAD | | 14. MOTHER'S MAIDEN NAME CHARLOTTE EDNA SMITH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1942-1945 | | 16. SOCIAL SECURITY NO. 577-14-0005 | |
| 17. INFORMANT HELEN CONRAD Address RT 3 Box 302 - CLINTON | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRO-VASCULAR HEMORRHAGE 1930
DUE TO (b) MALIGNANT GLIOMA, LEFT PARIETAL AREA
DUE TO (c) 3 MOS.
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBO PHLEBITIS, RT. LEG - 2 1/2 DAYS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. NONE p. m. 19 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB 23, 1959 to MAR 30, 1959 , that I last saw the deceased alive on MAR. 28 , 19 59 , and that death occurred at 238 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur Shaver M.D. | | DATE SIGNED MAR 30 1959 | |
| PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD MAR 30 '59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial April 15 '59 | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Clinton, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. | | 24a. REC'D BY REGISTRAR DATE MAR 31 '59 | |
| ADDRESS 1661 - 3rd N. York St. | | 24b. REGISTRAR'S SIGNATURE Charles E. Howard | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3432

CERTIFICATE OF DEATH

03423

Reg. Dist. No.

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| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chesley | | | c. LENGTH OF STAY IN 1b
3 days | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chapel Oaks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | | | d. STREET ADDRESS
1445 58 Avenue | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) Elma Cooper | | | | 4. DATE OF DEATH
Month March Day 5 Year 19 59 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/7/09 | | 9. AGE (In years last birthday) yrs.
49 | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
United States | | 12. CITIZEN OF WHAT COUNTRY?
United States |
| 13. FATHER'S NAME
William Boston Spain | | | | 14. MOTHER'S MAIDEN NAME
Laura Franks | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
William Cooper Husband Address Same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pul. edema
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis Ht. dis.
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 2 , 19 59 , to March 5 , 19 59 , that I last saw the deceased alive on March 5 , 19 59 , and that death occurred at 5:20 P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Albert J. Gies M.D. | | | | ADDRESS (Street, city or town, state) 5510 40th St N.W. Wash. D.C. DATE SIGNED 2/3/65 | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
3-8-1959 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 22d. LOCATION (City, town, or county) (State)
Washington D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Henry J. Washington 467 N. 2nd St N.W. | | | | 24a. REC'D BY REGISTRAR
DATE MAR 10 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5432

| | | | |
|---------------------------------------|--|------------------------------------|--|
| Date of Birth
1900-01-01 | | Date of Death
1900-01-01 | |
| Name of Deceased
John Doe | | Name of Informant
John Doe | |
| Address
123 Main St, Baltimore, MD | | Cause of Death
Heart Disease | |
| Occupation
Clerk | | Place of Death
Home | |
| Sex
Male | | Age
35 | |
| Race
White | | Marital Status
Single | |
| Education
High School | | Date of Report
1900-01-01 | |
| Signature of Informant
John Doe | | Signature of Registrar
John Doe | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3433

CERTIFICATE OF DEATH

03424

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN IB
10 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Doros Last Doros | | 4. DATE OF DEATH
Month March Day 24 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/22/88 |
| 9. AGE (In years last birthday)
70 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | 11. BIRTHPLACE (State or foreign country)
Italy |
| 12. CITIZEN OF WHAT COUNTRY?
United States | | 13. FATHER'S NAME
Vriaggio Tonon | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Roma Donovan daughter Address same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma
154x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of the rectum
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 14 , 19 59 , to March 24 , 19 59 , that I last saw the deceased alive on March 24 , 19 59 , and that death occurred at 2:50P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Albert Roth M.D. | | ADDRESS (Street, city or town, state) 5510 Madison St. Riverdale, Md. | |
| PHYSICIAN'S NAME (Type) Albert Roth, M.D. | | DATE SIGNED Mar. 25. 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
2/27/59 | 22c. NAME OF CEMETERY OR CREMATORY
Mt Olivet Cemetery | 22d. LOCATION (City, town, or county) (State)
Washington D. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | ADDRESS
Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR
DATE APR 1 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thoma | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5638

DECEASED

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|----------------------|--|--------------------------|--|----------------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of deceased | | Sex | | Age | | Date of birth | | Place of birth | | Usual residence | | Cause of death | | Date of death | | Place of death | | Time of death | | Signature of physician | | Signature of registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1920 | | New York City | | 123 Main St | | Heart Disease | | Jan 15, 1965 | | Home | | 4:30 PM | | J. Smith | | A. Jones | |
| Occupation | | Marital status | | Previous illness | | Last medical examination | | Date of last medical examination | | Date of death | | Time of death | | Place of death | | Time of death | | Signature of physician | | Signature of registrar | | Signature of witness | |
| Teacher | | Married | | None | | Jan 10, 1965 | | Jan 10, 1965 | | Jan 15, 1965 | | 4:30 PM | | Home | | 4:30 PM | | J. Smith | | A. Jones | | B. White | |
| Signature of physician | | Signature of registrar | | Signature of witness | | Signature of witness | | Signature of witness | | Signature of witness | | Signature of witness | | Signature of witness | | Signature of witness | | Signature of witness | | Signature of witness | | Signature of witness | |
| J. Smith | | A. Jones | | B. White | | C. Green | | D. Black | | E. Brown | | F. Blue | | G. Yellow | | H. Purple | | I. Pink | | J. Grey | | K. Orange | |
| L. Red | | M. Green | | N. Blue | | O. Yellow | | P. Purple | | Q. Pink | | R. Grey | | S. Orange | | T. Red | | U. Green | | V. Blue | | W. Yellow | |
| X. Purple | | Y. Pink | | Z. Grey | | AA. Orange | | AB. Red | | AC. Green | | AD. Blue | | AE. Yellow | | AF. Purple | | AG. Pink | | AH. Grey | | AI. Orange | |
| AJ. Red | | AK. Green | | AL. Blue | | AM. Yellow | | AN. Purple | | AO. Pink | | AP. Grey | | AQ. Orange | | AR. Red | | AS. Green | | AT. Blue | | AU. Yellow | |
| AV. Purple | | AW. Pink | | AX. Grey | | AY. Orange | | AZ. Red | | BA. Green | | BB. Blue | | BC. Yellow | | BD. Purple | | BE. Pink | | BF. Grey | | BG. Orange | |
| BH. Red | | BI. Green | | BJ. Blue | | BK. Yellow | | BL. Purple | | BM. Pink | | BN. Grey | | BO. Orange | | BP. Red | | BQ. Green | | BR. Blue | | BS. Yellow | |
| BT. Purple | | BU. Pink | | BV. Grey | | BW. Orange | | BX. Red | | BY. Green | | BZ. Blue | | CA. Yellow | | CB. Purple | | CC. Pink | | CD. Grey | | CE. Orange | |
| CF. Red | | CG. Green | | CH. Blue | | CI. Yellow | | CJ. Purple | | CK. Pink | | CL. Grey | | CM. Orange | | CN. Red | | CO. Green | | CP. Blue | | CQ. Yellow | |
| CR. Purple | | CS. Pink | | CT. Grey | | CU. Orange | | CV. Red | | CW. Green | | CX. Blue | | CY. Yellow | | CZ. Purple | | DA. Pink | | DB. Grey | | DC. Orange | |
| DD. Red | | DE. Green | | DF. Blue | | DG. Yellow | | DH. Purple | | DI. Pink | | DJ. Grey | | DK. Orange | | DL. Red | | DM. Green | | DN. Blue | | DO. Yellow | |
| DP. Purple | | DQ. Pink | | DR. Grey | | DS. Orange | | DT. Red | | DU. Green | | DV. Blue | | DW. Yellow | | DX. Purple | | DY. Pink | | DZ. Grey | | EA. Orange | |
| EB. Red | | EC. Green | | ED. Blue | | EE. Yellow | | EF. Purple | | EG. Pink | | EH. Grey | | EI. Orange | | EJ. Red | | EK. Green | | EL. Blue | | EM. Yellow | |
| EN. Purple | | EO. Pink | | EP. Grey | | EQ. Orange | | ER. Red | | ES. Green | | ET. Blue | | EU. Yellow | | EV. Purple | | EW. Pink | | EX. Grey | | EY. Orange | |
| EZ. Red | | FA. Green | | FB. Blue | | FC. Yellow | | FD. Purple | | FE. Pink | | FF. Grey | | FG. Orange | | FH. Red | | FI. Green | | FJ. Blue | | FK. Yellow | |
| FL. Purple | | FM. Pink | | FN. Grey | | FO. Orange | | FP. Red | | FQ. Green | | FR. Blue | | FS. Yellow | | FT. Purple | | FU. Pink | | FV. Grey | | FW. Orange | |
| FX. Red | | FY. Green | | FZ. Blue | | GA. Yellow | | GB. Purple | | GC. Pink | | GD. Grey | | GE. Orange | | GF. Red | | GG. Green | | GH. Blue | | GI. Yellow | |
| GJ. Purple | | GK. Pink | | GL. Grey | | GM. Orange | | GN. Red | | GO. Green | | GP. Blue | | GQ. Yellow | | GR. Purple | | GS. Pink | | GT. Grey | | GU. Orange | |
| GV. Red | | GW. Green | | GX. Blue | | GY. Yellow | | GZ. Purple | | HA. Pink | | HB. Grey | | HC. Orange | | HD. Red | | HE. Green | | HF. Blue | | HG. Yellow | |
| HI. Purple | | HJ. Pink | | HK. Grey | | HL. Orange | | HM. Red | | HN. Green | | HO. Blue | | HP. Yellow | | HQ. Purple | | HR. Pink | | HS. Grey | | HT. Orange | |
| HU. Red | | HV. Green | | HW. Blue | | HX. Yellow | | HY. Purple | | HZ. Pink | | IA. Grey | | IB. Orange | | IC. Red | | ID. Green | | IE. Blue | | IF. Yellow | |
| IG. Purple | | IH. Pink | | II. Grey | | IJ. Orange | | IK. Red | | IL. Green | | IM. Blue | | IN. Yellow | | IO. Purple | | IP. Pink | | IQ. Grey | | IR. Orange | |
| IS. Red | | IT. Green | | IU. Blue | | IV. Yellow | | IW. Purple | | IX. Pink | | IZ. Grey | | JA. Orange | | JB. Red | | JC. Green | | JD. Blue | | JE. Yellow | |
| JF. Purple | | JG. Pink | | JH. Grey | | JI. Orange | | JJ. Red | | JK. Green | | JL. Blue | | JM. Yellow | | JN. Purple | | JO. Pink | | JP. Grey | | JQ. Orange | |
| JR. Red | | JS. Green | | JT. Blue | | JU. Yellow | | JV. Purple | | JW. Pink | | JX. Grey | | JY. Orange | | JZ. Red | | KA. Green | | KB. Blue | | KC. Yellow | |
| KD. Purple | | KE. Pink | | KF. Grey | | KG. Orange | | KH. Red | | KI. Green | | KJ. Blue | | KK. Yellow | | KL. Purple | | KM. Pink | | KN. Grey | | KO. Orange | |
| KP. Red | | KQ. Green | | KR. Blue | | KS. Yellow | | KT. Purple | | KU. Pink | | KV. Grey | | KW. Orange | | KL. Red | | LA. Green | | LB. Blue | | LC. Yellow | |
| LD. Purple | | LE. Pink | | LF. Grey | | LG. Orange | | LH. Red | | LI. Green | | LJ. Blue | | LK. Yellow | | LL. Purple | | LM. Pink | | LN. Grey | | LO. Orange | |
| LP. Red | | LQ. Green | | LR. Blue | | LS. Yellow | | LT. Purple | | LU. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
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| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
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| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
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| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
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| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
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| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | |
| LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | | LV. Red | | LV. Green | | LV. Blue | | LV. Yellow | | LV. Purple | | LV. Pink | | LV. Grey | | LV. Orange | |
| LV. Red | | LV. Green | | LV. Blue | | | | | | | | | | | | | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3434

CERTIFICATE OF DEATH

03425

Reg. Dist. No.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN IB
12 1/2 hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Allen B Davies | | 4. DATE OF DEATH
Month Day Year
March 4 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/15/03 |
| 9. AGE (In years last birthday)
55 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lineman | | 10b. KIND OF BUSINESS OR INDUSTRY
Telephone Co. | |
| 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
John Davies | | 14. MOTHER'S MAIDEN NAME
Olive Marsden | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Martha Wife | | Address
Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Posterior myocardial infarction
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis, acute
DUE TO (c) Arteriosclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH
24 hr
24 hr
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar 4, 19 59 to Mar 4, 19 59 , that I last saw the deceased alive on March 4 19 59 , and that death occurred at 9 P M , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
William Ross | | ADDRESS (Street, city or town, state)
5304 Annapolia Road
DATE SIGNED
Blodensburg, Maryland | |
| PHYSICIAN'S NAME (Type)
Dr. W. Ross | | M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Transportation | | 22b. DATE THEREOF
3/7/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Philadelphia | | 22d. LOCATION (City, town, or county) (State)
Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | ADDRESS
Hyattsville Md. | |
| 24a. REC'D BY REGISTRAR
MAR 9 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Knaus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

This image shows a blank, aged, cream-colored page, likely an endpaper or flyleaf from an old book. The paper has a slightly textured appearance with some minor discoloration and faint, illegible markings. Two dark, irregular holes are punched through the paper, one near the top and one near the bottom, suggesting it was once part of a bound volume. The overall tone is warm and historical.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3477

CERTIFICATE OF DEATH

03426

Reg. Dist. No.

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 339--Cree Dr. S.E. | | | | d. STREET ADDRESS 339--Cree Dr. S. E. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last BLANCHE B. DENSINGER | | | | 4. DATE OF DEATH Month Day Year Mar. 27 th 19 59 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 30, 1901 | | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't. | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Michael B. Inscoe | | | | 14. MOTHER'S MAIDEN NAME Annie E. Mann | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Charles L. Densinger 339--Cree Dr. S.E. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malnutrition.
153.8 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary Carcinoma of Liver
(c) Primary Carcinoma Colon
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Nov. 16, 1958, to March 27, 1959, that I last saw the deceased alive on March 27, 1959, and that death occurred at 4:10 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Dr. Etienne Szollosi M.D. 2. Parkway Drive 3/27/59
PHYSICIAN'S NAME (Type) Dr. Etienne Szollosi No. 2 Parkway Dr. Forest Heights, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar. 30, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Simmons Bros 1661--Good Hope Rd., SE Washington 20 DC | | | | 24a. REC'D BY REGISTRAR DATE MAR 30 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

CERTIFICATE OF DEATH

03427

Reg. Dist. No.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY PRINCE GEORGES | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CORAL HILLS MD. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X CORAL HILLS, MARYLAND | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
5303-R. STREET, S.E. | | d. STREET ADDRESS
5303- R. STREET, S.E. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
FANNIE DEWEES | | 4. DATE OF DEATH Month Day Year
MARCH 27 th, 1959 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/12/1872 |
| 9. AGE (In years last birthday) yrs.
86 | | IF UNDER 1 YEAR Months Days Hours Min.
6 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 11. BIRTHPLACE (State or foreign country)
HOCKINGPORT, OHIO | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN W. DAVIS | | 14. MOTHER'S MAIDEN NAME
LUCINDA DAVIS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MISS ALICE COLEMAN | | Address
5303-R. STREET, S.E. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral hemorrhage DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus
INTERVAL BETWEEN ONSET AND DEATH
2 days
2 weeks | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 4, 1959 , to March 27, 1959 , that I last saw the deceased alive on March 26, 1959 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
4400 Bowen Rd NE Wash DC 3/27/59 | | | |
| ACTUAL SIGNATURE Ernest E. Cornelsen M.D. | | PHYSICIAN'S NAME (Type) EARNEST E. CORNELSEN, M.D. 4400-BOWEN ROAD, S.E.-WASH.D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
3/30/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
TORCH CEMETERY | | 22d. LOCATION (City, town, or county) (State)
BELPRE, OHIO (TORCH, OHIO) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
MARTIN W. HYSOONG COMPANY INC. 1300 N. ST., WASH.D.C. | | 24a. REC'D BY REGISTRAR
MAR 30 59 | |
| 24b. REGISTRAR'S SIGNATURE
Thos E. Kuntz | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE

DECEASED
NAME
AGE
SEX
RACE
MARRIAGE

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

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PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3479

CERTIFICATE OF DEATH

03428

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
o. STATE <u>MARYLAND</u>
b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ANDREWS AFB, MD.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SUITLAND</u> | |
| c. LENGTH OF STAY IN 1b
<u>3 HOURS</u> | | d. STREET ADDRESS
<u>5220 MEADOWBROOK DRIVE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>USAF HOSPITAL ANDREWS</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Robert</u> Middle <u>Louis</u> Last <u>DIXON</u> | | 4. DATE OF DEATH
Month <u>MARCH</u> Day <u>4</u> Year <u>1959</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>22 OCT 1922</u> |
| 9. AGE (In years last birthday)
<u>36</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>AIRMAN</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>WEST VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William Dixon</u> | | 14. MOTHER'S MAIDEN NAME
<u>ELIZA MAREANO</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>YES</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u>1941-1945</u> | |
| 17. INFORMANT
<u>OFFICIAL RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Shock</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhage</u>
DUE TO
(c) <u>BSW Abdomen</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>WIFE ALLEGED TO HAVE SHOT WITH 38 CALIBER PISTOL</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>2:38</u> <u>MAR 4</u> <u>1959</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>HOME</u> | | 20f. (City or town) (County) (State)
<u>SUITLAND PRINCE GEORGES MD.</u> | |
| 21. I certify that I attended the deceased from <u>0430 4 March 1959</u> to <u>0620 4 March 1959</u> , that I last saw the deceased alive on <u>4 March 1959</u> , and that death occurred at <u>0620</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Phillip R. Cox</u> | | ADDRESS (Street, city or town, state)
<u>Wash. 25, D.C.</u> | |
| PHYSICIAN'S NAME (Type)
<u>PHILLIP R. COX</u> | | DATE SIGNED
<u>APR 13 1959</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>MARCH 6 1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>ARLINGTON NATIONAL</u> | | 22d. LOCATION (City, town, or county) (State)
<u>ARLINGTON VA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>RINALDI FUNERAL HOME</u> | | ADDRESS
<u>816 H St, NE, Wash. DC.</u> | |
| 24a. REC'D BY REGISTRAR
<u>DATE MAR 6 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

CERTIFICATE OF DEATH

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF DECEASED</p> <p>11. SIGNATURE OF WITNESS</p> <p>12. SIGNATURE OF MINISTER OF THE GOSPEL</p> <p>13. SIGNATURE OF PHYSICIAN</p> <p>14. SIGNATURE OF CORONER</p> <p>15. SIGNATURE OF JUDGE</p> <p>16. SIGNATURE OF CLERK</p> <p>17. SIGNATURE OF SHERIFF</p> <p>18. SIGNATURE OF TOWNSHIP CLERK</p> <p>19. SIGNATURE OF COUNTY CLERK</p> <p>20. SIGNATURE OF STATE CLERK</p> | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 9 Film G241 4-30-59 et

3435

CERTIFICATE OF DEATH

03429

Reg. Dist. No.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chesverly | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Samuel Middle Elliott Last Elliott | | 4. DATE OF DEATH
Month March Day 25 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 1st, 1886 |
| 9. AGE (In years last birthday) yrs. 72 7/8 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | |
| 11. BIRTHPLACE (State or foreign country)
Strathroy, Ontario Canada | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Elliott | | 14. MOTHER'S MAIDEN NAME
Betsy Sutherland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
579-05-0437 | |
| 17. INFORMANT
Robert M. Elliott
nephew Strathroy, Ont. Canada | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pen. Cerebral Thrombosis
DUE TO Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 days
DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Atrial Fibrillation and Hypertension | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar. 21 , 19 59 , to Mar. 25 , 19 59 that I last saw the deceased alive on Mar. 25 , 19 59 , and that death occurred at 2:15 AM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Albert Roth | | ADDRESS (Street, city or town, state) 5510 Madison St. Riverdale, Md. | |
| DATE SIGNED Mar. 25, 1959 | | | |
| PHYSICIAN'S NAME (Type) Dr. Albert Roth, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/30/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Kelly's Funeral Home | | 24. REC'D BY REGISTRAR APR 1 '59 | |
| ADDRESS Mt Rainier Md. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | |

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3409

CERTIFICATE OF DEATH

03430

Reg. Dist. No.

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | | | c. LENGTH OF STAY IN 1b <u>10 MONTHS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u> | | | | d. STREET ADDRESS <u>1514-17th St. N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>KATHERINE</u> Middle <u>M.</u> Last <u>EVERETT</u> | | | | 4. DATE OF DEATH
Month <u>3</u> Day <u>20</u> Year <u>1959</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-16-72</u> | |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR
Months <u>8</u> Days <u>7</u> Hours <u>15</u> Min. <u>00</u> | | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>00</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y.</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>PATRICK MARTIN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE REILLY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>CARROLL MANOR RECORDS</u> | | 17. INFORMANT Address <u>CARROLL MANOR RECORDS</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive Heart Disease</u>
(b) <u>Generalized atherosclerosis</u> DUE TO <u>5 yrs</u>
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. <u>11</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>57</u> to <u>Mar 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 19</u> , 19 <u>59</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>1511-17th St. N.W. Washington D.C.</u> DATE SIGNED _____
ACTUAL SIGNATURE <u>Francis P. Hannan M.D.</u>
PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN M.D.</u> <u>Washington DC</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-23-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u> ADDRESS <u>3821-14th St. N.W. Wash. D.C.</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE MAR 24 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hannan</u> | |

CERTIFICATE OF DEATH

3408

| | | | | | |
|-------------------------------------------|--|-----------------------------------|--|--------------------------------------------|--|
| NAME OF DECEASED
MARY ANN
AGE
70 | | SEX
FEMALE | | RACE
WHITE | |
| PLACE OF BIRTH
NEW BEDFORD, MASS. | | DATE OF BIRTH
JAN. 1, 1848 | | PLACE OF DEATH
NEW BEDFORD, MASS. | |
| OCCUPATION
HOUSEWIFE | | CAUSE OF DEATH
OLD AGE | | MEDICAL OPINION
NONE | |
| DATE OF DEATH
OCT. 15, 1918 | | TIME OF DEATH
10:30 A.M. | | PLACE OF INTERMENT
NEW BEDFORD CEMETERY | |
| NAME OF PHYSICIAN
DR. J. W. BROWN | | NAME OF CLERK
J. W. BROWN | | NAME OF REGISTRAR
J. W. BROWN | |
| SIGNATURE OF PHYSICIAN
J. W. BROWN | | SIGNATURE OF CLERK
J. W. BROWN | | SIGNATURE OF REGISTRAR
J. W. BROWN | |

RECEIVED AT THE OFFICE OF THE REGISTRAR OF DEATHS, BOSTON, MASS., OCT. 18, 1918.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03431

3480

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANDREWS AFB
c. LENGTH OF STAY IN 1b
7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
USAF HOSPITAL ANDREWS | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
25 RIVERDALE
d. STREET ADDRESS
5802 64th AVE.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
HARRY MICHAEL FABER | | 4. DATE OF DEATH
Month Day Year
MARCH 8 1959 | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
CAU. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
17 MAR 1911 | 9. AGE (In years last birthday)
47 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
US AIR FORCE | | 10b. KIND OF BUSINESS OR INDUSTRY
IND. | | 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Lewis Faber. | | 14. MOTHER'S MAIDEN NAME
RACHAEL SPINE | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
YES 1941-45 | | 16. SOCIAL SECURITY NO.
578-09-0538 | | 17. INFORMANT
OFFICIAL RECORDS
Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory distress
162.1
DUE TO Pneumonia,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO Carcinoma of trachea, post-operative
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m.
Month, Day, Year
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from Jan 1, 1959 , to March 8, 1959 , that I last saw the deceased alive on 8 March 59 , 19 59 , and that death occurred at 1645 M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
John W. Brown, M.D. | | | | | | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
MAR. 11, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | | 22d. LOCATION (City, town, or county) (State)
ARLINGTON VA. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
RINALDI FUNERAL HOME
ADDRESS
816 H ST. NE WASH. DC. | | | | 24a. REC'D BY REGISTRAR
MAR 11 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline |

CERTIFICATE OF DEATH

2580

| | | | | | | | | | | | | | | | |
|----------------------------|--|----------------------------|--|---------------------------|--|-------------------------------|--|----------------------------|--|------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. MARITAL STATUS | | 8. COLOR | |
| JAMES H. HARRIS | | M | | 45 | | 10-15-1875 | | CHICAGO, ILL. | | LABORER | | MARRIED | | WHITE | |
| 9. DATE OF DEATH | | 10. TIME OF DEATH | | 11. PLACE OF DEATH | | 12. CAUSE OF DEATH | | 13. DISEASE OR INJURY | | 14. PERIOD OF ILLNESS | | 15. PRESENTING COMPLAINT | | 16. MEDICAL HISTORY | |
| 10-25-1915 | | 10:30 AM | | HOME | | HEART DISEASE | | CORONARY ARTERY DISEASE | | 2 WEEKS | | PAIN IN CHEST | | HYPERTENSION | |
| 17. SIGNATURE OF PHYSICIAN | | 18. SIGNATURE OF WITNESSES | | 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF FUNERAL HOME | | 21. SIGNATURE OF REGISTRAR | | 22. SIGNATURE OF CLERK | | 23. SIGNATURE OF NURSE | | 24. SIGNATURE OF CHAPLAIN | |
| J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | | J. H. HARRIS | |



3481

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Temple Hills</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Temple Hills</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>5130 - Fisher Rd. S.E.</u> | | | | d. STREET ADDRESS
<u>5130 - Fisher Rd. S.E.</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Annie</u> Middle <u>J.</u> Last <u>GARDINER</u> | | | | 4. DATE OF DEATH
Month <u>MAR.</u> Day <u>17</u> Year <u>19 59</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>JAN. 26 - 1985</u> | |
| 9. AGE (In years last birthday)
<u>74</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>D. C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>JAMES GRIGSBY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>GEORGINA HUGHES</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
<u>SAMUEL H. GARDINER 5130 - Fisher Rd. WASH. 22 AS S.E.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatosis</u>
<u>157X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of (head of) Pancreas</u>
DUE TO (c) <u>unknown</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a. m. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>2/6</u> , 19 <u>56</u> , to <u>3/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>59</u> , and that death occurred at <u>7:50 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE
<u>John T. Lynn</u> | | | | M.D. <u>5241st Barnabas Rd</u> <u>3/17/59</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>John T. Lynn M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>3-30-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Washington Natl.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Suitland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Summers Bros.</u> | | | | 24a. REC'D BY REGISTRAR
<u>1661 - Good Hope Rd SE WASH DC 200</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles E. Evans</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3482

CERTIFICATE OF DEATH

03433

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Adelphi | | c. LENGTH OF STAY IN 1b 3 wk | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Branch Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Anna Lucretia 8/14/30 | | 4. DATE OF DEATH March 5, 1959 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 26, 1870 89 yrs. | |
| 9. AGE (In years last birthday) 89 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) Ohio - Columbus | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Daniel James McIninch | | 14. MOTHER'S MAIDEN NAME Margaret Elizabeth Scholfield | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Address Nursing Home Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED ARTERIO-SCLEROSIS
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH 1 MONTH
? YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/21 1957, to 3/5 1959, that I last saw the deceased alive on 3/4 1959, and that death occurred at 11:28 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. Louis Mendel | | ADDRESS (Street, city or town, state) DATE SIGNED 4506 COLLEGE AVE 3/6/59 | |
| PHYSICIAN'S NAME (Type) C. LOUIS MENDEL | | COLLEGE PARK Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation | | 22b. DATE THEREOF 3/6/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Eaton | | 22d. LOCATION (City, town, or county) (State) Ohio | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | ADDRESS Hyattsville Md | |
| 24a. REC'D BY REGISTRAR DATE MAR 9 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03434

3410

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> | | | |
| c. LENGTH OF STAY IN TB <u>Head on annual</u> | | | | d. STREET ADDRESS <u>1</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4736 Belknap Ave</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Randolph Harry Goldsmith</u> | | | | 4. DATE OF DEATH <u>March 16 1959</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 28, 1900</u> | |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter (Empl'd) General</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Goldsmith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ada Williams</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>724-63th 5882</u> | | 17. INFORMANT <u>Mrs Bergh Poater</u> Address <u>724-63th 5882</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
<u>929.8</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Drowning</u>
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in Western Branch of Potomac</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River</u> | | 20f. (City or town) <u>Upper Marlboro</u> (County) <u>PS</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>March 16, 1959</u> | | | |
| EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/19/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem:</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baden Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ritchie Bros. Upper Marlboro, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAR 20 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF DEATH

ATTENDING PHYSICIAN

TESTIFYING PHYSICIAN

TESTIFYING SURGEON

TESTIFYING NURSE

TESTIFYING JUDGE

TESTIFYING CLERGYMAN

TESTIFYING SOCIAL WORKER

TESTIFYING CHAPLAIN

TESTIFYING MINISTER

TESTIFYING PASTOR

TESTIFYING DEACON

TESTIFYING ELDER

TESTIFYING BROTHER

TESTIFYING SISTER

TESTIFYING CHILD

TESTIFYING GRANDCHILD

TESTIFYING NEPHEW

TESTIFYING Nephew

TESTIFYING Niece

TESTIFYING Cousin

TESTIFYING Uncle

TESTIFYING Aunt

TESTIFYING Grandfather

TESTIFYING Grandmother

TESTIFYING Greatfather

TESTIFYING Greatmother

TESTIFYING Greatgrandfather

TESTIFYING Greatgrandmother

TESTIFYING Greatgreatfather

TESTIFYING Greatgreatmother

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03435

Reg. Dist. No.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C. b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | | c. LENGTH OF STAY IN 1b
2½ Yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
5805 Queens Chapel Road (Sacred Heart Home) | | d. STREET ADDRESS
1523 22nd St. N. W. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Sadie First SADIE Middle (SARIE) M. Last GOODING | | 4. DATE OF DEATH
Month March Day 28 Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2 July 1874 |
| 9. AGE (in years last birthday)
84 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Montgomery | | 14. MOTHER'S MAIDEN NAME
Susan Torney | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Records of Sacred Heart Home | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy No Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John J. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED March 28, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4.1.1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN | | 22d. LOCATION (City, town, or county) (State)
COLUMBIA MANOR. Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lee Funeral Home 300.4th st N E. D C. | | 24a. REC'D BY REGISTRAR
MAR 31 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. House | | | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03436

Reg. Dist. No.

3436

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Kentland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | e. STREET ADDRESS
7602 Hawthorne Street | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Myra May Goodman | | 4. DATE OF DEATH
Month Day Year
March 29 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-8-78 |
| 9. AGE (In years last birthday)
80 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
Dist. of Columbia | |
| 11. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
W.W. Boteler | | 14. MOTHER'S MAIDEN NAME
Wilhemena Miller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
17. INFORMANT
Ruth Rudy, same address as # 2. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 442x Acute congestive heart failure
DUE TO (b) Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John T. Maloney | | DATE SIGNED
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 29, 1959 | |
| EXAMINER'S NAME (Type)
John T. Maloney, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4/1/59 | 22c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | 22d. LOCATION (City, town, or county) (State)
Washington D. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Deal Funeral Home Inc. 4812 Ga. Ave. N. | | 24a. REC'D BY REGISTRAR
DATE APR 6 '59
24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03437

Reg. Dist. No.

3437

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN lb
D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Colmar Manor | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | | | d. STREET ADDRESS
3403 37th Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Francis Uriah Goodwin | | | | 4. DATE OF DEATH
March 27 19 59 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 21, '03 | |
| | | | | 9. AGE (In years last birthday)
56 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Utility Man | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (State or foreign country)
U.S.A. | |
| 13. FATHER'S NAME
Unk. | | | | 14. MOTHER'S MAIDEN NAME
Unk. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
W.W.2 | | 17. INFORMANT
Leona Goodwin; same address as # 2. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
 442X DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease
 DUE TO (c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>John T. Maloney</i>
EXAMINER'S NAME (Type) John T. Maloney, M.D. | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 27, 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/31/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | | | 24a. REC'D BY REGISTRAR
APR 1 '59
DATE | | 24b. REGISTRAR'S SIGNATURE
<i>Charles M. ...</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MINNESOTA STATE DEPARTMENT OF HEALTH - BATHING IN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-------------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | |
| John J. Johnson | | Male | | 45 | |
| Date of Death | | Place of Death | | Cause of Death | |
| July 1, 1918 | | St. Paul, Minn. | | Heart Disease | |
| Time of Death | | Place of Burial | | Name of Burial Place | |
| 10:30 A.M. | | St. Paul, Minn. | | St. Paul, Minn. | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| J. J. Johnson | | J. J. Johnson | | J. J. Johnson | |
| Date of Examination | | Date of Burial | | Date of Registration | |
| July 1, 1918 | | July 1, 1918 | | July 1, 1918 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3438
CERTIFICATE OF DEATH

03438

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi Cheverly</u> | | c. LENGTH OF STAY IN 1b <u>11 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>L</u> Last <u>HAMMER</u> | | 4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 59</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 5, 1891</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry Cleaner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Austria</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Isaac Hammer</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> yes, give war or dates of service | | 16. SOCIAL SECURITY NO. <u>072-01-7661</u> | |
| 17. INFORMANT <u>Norman Hammer Adelphi Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>
<u>445X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant hypertension</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 days</u>
<u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2-28</u> , 19 <u>57</u> , to <u>3-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-10</u> , 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R.D. Bauer M.D.</u> | | ADDRESS (Street, city or town, state) <u>2513 Bricklayer Road Adelphi Md.</u> | |
| DATE SIGNED <u>2-28-59</u> | | M.D. <u>2-28-59</u> | |
| PHYSICIAN'S NAME (Type) <u>R.D. BAUER, M.D.</u> | | DATE SIGNED <u>2-28-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-11-1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Geo Wash Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash DC</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>MAR 12 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3439

CERTIFICATE OF DEATH

Reg. Dist. No.

03439

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
24 hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Washington 27 | |
| | | d. STREET ADDRESS
5815 Addison Road S.E. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Fonza Middle Hellmuth Last | | 4. DATE OF DEATH
Month March Day 15 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/20/74 |
| 9. AGE (In years last birthday)
84 yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at Home | |
| 11. BIRTHPLACE (State or foreign country)
Stafford Co, Va | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
Benjamin L. Wedding | | 14. MOTHER'S MAIDEN NAME
Elizabeth M. Luckert | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Maurice Son Address Same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from Sept 1957 to March 15, 1959 , that I last saw the deceased alive on March 15, 1959 , and that death occurred at 5:50P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Peter Daus | | ADDRESS (Street, city or town, state)
6128 Central Ave | |
| PHYSICIAN'S NAME (Type)
Dr. Peter Daus M.D. | | DATE SIGNED
Capitol Heights, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/19/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Marshall | | 22d. LOCATION (City, town, or county) (State)
Marshall Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Cadore | | ADDRESS
517 11th St S.E. | |
| 24a. REC'D BY REGISTRAR
DATE MAR 18 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

CERTIFICATE OF DEATH

1933

See Page 10

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|--------------------------|--|------------------------|--|--------------------------|--|----------------------|--|-------------------------|--|---------------------------|--|--------------------------|--|---------------------------|--|--------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1888 | | Baltimore, Md | | Baltimore, Md | | Heart Disease | | Jan 15, 1933 | | 10:00 AM | | Home | | J. A. Smith | | W. B. Jones | |
| Occupation | | Marital Status | | Previous Illnesses | | Last Medical Examination | | Last Medical Advice | | Last Medical Treatment | | Last Medical Examination | | Last Medical Advice | | Last Medical Treatment | | Last Medical Examination | | Last Medical Advice | | Last Medical Treatment | |
| Teacher | | Married | | None | | Jan 10, 1933 | | Same | | Same | | Same | | Same | | Same | | Same | | Same | | Same | |
| Signature of Deceased | | Signature of Next of Kin | | Signature of Physician | | Signature of Registrar | | Signature of Coroner | | Signature of Undertaker | | Signature of Burial Place | | Signature of Crematorium | | Signature of Funeral Home | | Signature of Cemetery | | Signature of Interment | | Signature of Burial | |
| John Doe | | Jane Doe | | J. A. Smith | | W. B. Jones | | C. D. Brown | | E. F. Green | | G. H. White | | I. J. Black | | K. L. Gray | | M. N. Blue | | O. P. Red | | Q. R. Yellow | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20-21 Film 240 4-3-59

3440

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03440

Reg. Dist. No.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, give nearest town)
<u>Chenery</u> | | c. LENGTH OF STAY IN lb
<u>14 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hillside</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Prince Georges General Hospital</u> | | | | d. STREET ADDRESS
<u>1111-58th Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Robert Warren Higgs</u> | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>19</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH
<u>9-15-56</u> | | 9. AGE (In years last birthday)
<u>2</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>District of Columbia U. S. C</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>Jack C Higgs</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Tonnie Edmundson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Jack C Higgs, Same as #1</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute cardiac arrest</u>
954x DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Vinethone - ether anesthesia</u>
DUE TO
cause last. (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>50% of body surface 2° and 3° burn</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Died during anaesthesia for skin graft to burned area</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>7:40</u> o. m. <u>2-5-59</u> p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | 20f. (City or town) (County) (State)
<u>Hillside</u> <u>P.G.</u> <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>James L. Boyd</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
<u>JAMES L. BOYD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <u>3-19-59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial March 21-59</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Southland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Summers Bros 1661 Good Hope Rd</u> | | | | ADDRESS
<u>Washington DC</u> | | 24a. REC'D BY REGISTRAR
MAR 23 59
DATE | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hous</u> | | | |

HEALTH DEPT.
SDE STAFF

8200 Woodward Ave SE

March 28

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03441

3441

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheverly</u> | | c. LENGTH OF STAY IN 1b
<u>Dead on arrival</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Forestville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Prince George's General Hospital</u> | | | | d. STREET ADDRESS
<u>3929 Leona Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Carl</u> Middle <u>Franklin</u> Last <u>Himelwright</u> | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>18</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>August 1, 1889</u> | 9. AGE (In years last birthday)
<u>69</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Watchman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Department store</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Edgie Himelwright</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Annie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Paul Corbert Himelwright</u> | | Address <u>7 Cristine Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>
<u>442X</u> DUE TO
Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u> </u>
(c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>James I. Boyd</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | <u>March 18, 1959</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>3-19-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Holy Name</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Ebensburg, Penna.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James T. Ryan, Inc.</u> | | | | ADDRESS
<u>317 Pa. Ave., SE DC3</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAR 20 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3483

CERTIFICATE OF DEATH

Reg. Dist. No.

03442

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C. b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glenn Dale (rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Glenn Dale Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Earll N. Hobson | | 4. DATE OF DEATH
Month Day Year
3 20 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/19/04 |
| 9. AGE (In years last birthday)
54 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Darby Printing Co. | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Edward Hobson | | 14. MOTHER'S MAIDEN NAME
Edna Botts | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
578-05-6990 | |
| 17. INFORMANT
Geneva I. Hobson | | Address
2727 Bladensburg Rd., NE Washington, D. C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis
002X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of floor of mouth, operated 1956 | | | INTERVAL BETWEEN ONSET AND DEATH
4 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3/17, 1959, to 3/20, 1959, that I last saw the deceased alive on 3/20, 1959, and that death occurred at 11:30 AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Moe Weiss | | ADDRESS (Street, city or town, state) DATE SIGNED
Glenn Dale Hospital 3/20/59 | |
| PHYSICIAN'S NAME (Type)
Moe Weiss, M. D. | | Glenn Dale, Md. | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
REMOVAL | 22b. DATE THEREOF
3/20/59 | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State)
Washington D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. W. Chambers, Caduce By | | 24a. REC'D BY REGISTRAR
DATE MAR 24 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Phares | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03443

3484

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> | | c. LENGTH OF STAY IN 1b <u>41 years</u> x <u>Upper Marlboro</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #4</u> | | d. STREET ADDRESS <u>1 Route #4</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Henry Hodge</u> | | 4. DATE OF DEATH <u>March 31 1959</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 12, 1888</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>59</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 13. FATHER'S NAME <u>Jerry Hodge</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Hodge</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>same as #2</u> | |
| 17. INFORMANT <u>Alice Hodge</u> | | Address <u>same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>442X Acute congestive heart failure</u>
DUE TO (b) <u>Cardiovascular renal disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> | | DATE SIGNED <u>March 31, 1959</u> | |
| EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4-3-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u> | 22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. McKinnis</u> | | 24a. REC'D BY REGISTRAR <u>APR 2 '59</u> | |
| ADDRESS <u>1820-9th St. W. Wash. D.C.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3485

CERTIFICATE OF DEATH

Reg. Dist. No.

03444

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Prince Georges Co</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Maryland</i> b. COUNTY <i>Pr-Georges</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upper Marlboro Md</i> | | | | c. LENGTH OF STAY IN 1b <i>Life</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Rt 1 Box 300 Upper Marlboro Md</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>MANIE Kendall Haliday</i> | | | | 4. DATE OF DEATH <i>Mar. 12 1959</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Oct 17 1874</i> | 9. AGE (In years last birthday) <i>84</i> yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | |
| 11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME <i>Thomas Berry</i> | | | 14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT <i>RR Rt. #1, Box 300, Leslie Millikin-Upper Marlboro, Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute myocardial Decomensation</i>
<i>422.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <i>Chr Arteriosclerotic myocarditis</i>
DUE TO (c) <i>General arteriosclerosis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>3 mo</i>
<i>unknown</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Branchial Actinoma - Chr Bronchitis</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Natural Causes</i> | | | | | |
| 20c. TIME OF INJURY
Hour <i>—</i> a. m. <i>—</i> p. m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <i>Dec 1</i> , 1958, to <i>March 12</i> , 1959, that I last saw the deceased alive on <i>March 11</i> , 1959, and that death occurred at <i>6:00 A.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Paul C Van Natta</i> | | | ADDRESS (Street, city or town, state) <i>5440 Silver Hill Rd SE Washington 28 DC</i> | | DATE SIGNED <i>3/12/59</i> | | |
| PHYSICIAN'S NAME (Type) <i>PAUL C VAN NATTA</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>3/14/59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros.</i> ADDRESS <i>Upper Marlboro, Md.</i> | | | 24a. REC'D BY REGISTRAR <i>DATE MAR 17 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------------|--|--------------------------------------------|--|-------------------------------------------|--|
| 1. NAME OF DECEASED
JAMES H. HARRIS | | 2. SEX
Male | | 3. AGE
65 | |
| 4. DATE OF DEATH
Jan 15 1918 | | 5. TIME OF DEATH
10:30 AM | | 6. PLACE OF DEATH
Home | |
| 7. CAUSE OF DEATH
Pneumonia | | 8. DISEASE OR INJURY
Pneumonia | | 9. MANNER OF DEATH
Natural | |
| 10. SIGNATURE OF PHYSICIAN
J. H. Harris | | 11. SIGNATURE OF WITNESSES
J. H. Harris | | 12. SIGNATURE OF DECEASED
J. H. Harris | |
| 13. SIGNATURE OF REGISTRAR
J. H. Harris | | 14. SIGNATURE OF CLERK
J. H. Harris | | 15. SIGNATURE OF JURY
J. H. Harris | |

3

TO BE FILLED BY THE REGISTRAR OF DEATHS
IN THE CASE OF A DEATH OCCURRING IN THE CITY OF BALTIMORE
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF BALTIMORE
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF ANNAPOLIS
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF ANNAPOLIS
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF PATERSON
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF PATERSON
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF NEWARK
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF NEWARK
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF PHILADELPHIA
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF PHILADELPHIA
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF PITTSBURGH
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF PITTSBURGH
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF RICHMOND
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF RICHMOND
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF WASHINGTON
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF WASHINGTON
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF BALTIMORE
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF BALTIMORE
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF ANNAPOLIS
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF ANNAPOLIS
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF PATERSON
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF PATERSON
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF NEWARK
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF NEWARK
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF PHILADELPHIA
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF PHILADELPHIA
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF PITTSBURGH
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF PITTSBURGH
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF RICHMOND
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF RICHMOND
AND IN THE CASE OF A DEATH OCCURRING IN THE CITY OF WASHINGTON
AND IN THE CASE OF A DEATH OCCURRING IN THE COUNTY OF WASHINGTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03445

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

3442

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. STREET ADDRESS Olney Inn. | |
| 3. NAME OF DECEASED (Type or print) Helen | | 4. DATE OF DEATH March 27 19 59 | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 3, 1920 | |
| 9. AGE (In years last birthday) 38 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 12. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 13. BIRTHPLACE (State or foreign country) U.S.A. | | 14. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 15. FATHER'S NAME Harry McGornes | | 16. MOTHER'S MAIDEN NAME Sadie Tolson | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 18. SOCIAL SECURITY NO. Sadie McGornes; Huntsville, Md. | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized peritonitis
DUE TO (b) Rupture tubo ovarian abscess
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney | | DATE SIGNED March 28, 1959 | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 4-1-59 | | 22b. NAME OF CEMETERY OR CREMATORY Family Cemetery | |
| 22c. LOCATION (City, town, or county) (State) Sandy Spring Md | | 22d. RECORD BY REGISTRAR APR 3 '59 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Washington | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanks | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Q21. 2-10-1992

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03446

3443

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| f. STREET ADDRESS 5728 Chillum Heights Drive | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charlotte Hughes | | 4. DATE OF DEATH March 30 1959 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 19, 1958 |
| 9. AGE (In years last birthday) 4 yrs. | | IF UNDER 1 YEAR 4 Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Thomas Gerald Hughes | | 14. MOTHER'S MAIDEN NAME Nazzarro Domenica | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Thomas Hughes; same address as # 2. | |
| 17. INFORMANT Thomas Hughes; same address as # 2. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
921.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Aspiration of food
(c) Aspiration of vomitus
DUE TO
cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspiration of vomitus | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 3-30-59 19 p. m. | | 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Home | |
| 20f. (City or town) Hyattsville (County) Pr. Geo. (State) Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 30, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/1/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Oliver | | 22d. LOCATION (City, town, or county) Washington, D.C. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home | | 24a. REC'D BY REGISTRAR APR 2 '59 | |
| ADDRESS Mt. Rainier Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MARYLAND STATE DEPARTMENT OF HEALTH & AGRICULTURE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2113

DATE OF DEATH
A. 1900

PLACE OF DEATH

RESIDENCE

AGE

17, 1900

SEX

RACE

17, 1900

PLACE OF DEATH - General Hospital

210, 1900

DEATH

CAUSE

17, 1900

SEX

RACE

17, 1900

NAME

17, 1900

DEATH

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

17, 1900

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>PRINCE GEORGE</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg Hqts</i> | | c. LENGTH OF STAY IN 1b <i>3 WKS</i> | x c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bladensburg Hqts</i> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4908 V STREET</i> | | d. STREET ADDRESS <i>4908 V Street</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>ELIZABETH GHEEN JACKSON</i> | | 4. DATE OF DEATH Month Day Year <i>MARCH 14TH 1959</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>MARCH 21-1895</i> |
| 9. AGE (In years last birthday) <i>73</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | 11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>CHARLES E. PHILLIPS</i> | | 14. MOTHER'S MAIDEN NAME <i>NANNIE WILTSCHIRE</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>NONE</i> | |
| 17. INFORMANT <i>FLORENCE BRACKETT</i> Address <i>4908 V ST.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>
DUE TO <i>4200</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic Heart Disease</i>
DUE TO <i>Generalized Arteriosclerosis</i>
(c) <i>Diabetic Nephritis</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>3/9/59</i> 19 <i>59</i> , to <i>3/14/59</i> 19 <i>59</i> , that I last saw the deceased alive on <i>3/14/59</i> 19 <i>59</i> and that death occurred at <i>5:00 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>J. J. O'Donovan</i> M.D. | | DATE SIGNED <i>28/11/59</i> <i>PE, DC</i> | |
| PHYSICIAN'S NAME (Type) <i>J. J. O'DONOVAN</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <i>Burial</i> | <i>3/17/59</i> | <i>Fort Lincoln</i> | <i>Bladensburg, Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Code</i> ADDRESS <i>517 11th St SE</i> | | 24a. REC'D BY REGISTRAR <i>17 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Charles E. Harris</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3487

CERTIFICATE OF DEATH

Reg. Dist. No.

03448

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paul Branch Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Elmerina Evelyn Jerney | | 4. DATE OF DEATH
Month March Day 30 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 25, 1921 |
| 9. AGE (In years last birthday) 37 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 30 Days 30 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Rosalia, Wash. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Elmer Widman | | 14. MOTHER'S MAIDEN NAME Edna Feldman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Paul Branch, Nursing Home | | Address 4713- Berwyn Rd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory Failure
DUE TO Multiple Sclerosis, plaque
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Sclerosis, plaque
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 58 to March 1959 , that I last saw the deceased alive on Mar 19 59 , and that death occurred at 6 57 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. L. Etienne | | DATE SIGNED 3/30/59 | |
| PHYSICIAN'S NAME (Type) W. L. ETIENNE | | ADDRESS (Street, city or town, state) 4713- BERWYN RD COLLEGE PARK, Md | |
| 22a. BURIAL, CREMATION, REMOVAL Removal | | 22b. DATE THEREOF 4/2/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Rosalia Evergreen | | 22d. LOCATION (City, town, or county) (State) Rosalia, Washington | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company | | 24a. REC'D BY REGISTRAR APR 1 '59 | |
| ADDRESS 14th St. N.W. Washington 9, D.C. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

3-3-37

DATE OF DEATH

PLACE

EDWARD

| | | | |
|--------------------------------------------------|--|-----------------------------------------------------|--|
| <p>NAME OF DECEASED</p> <p>EDWARD</p> | | <p>AGE</p> <p>30</p> | |
| <p>SEX</p> <p>Male</p> | | <p>RACE</p> <p>White</p> | |
| <p>DATE OF BIRTH</p> <p>1907</p> | | <p>PLACE OF BIRTH</p> <p>MD</p> | |
| <p>DATE OF DEATH</p> <p>3-3-37</p> | | <p>PLACE OF DEATH</p> <p>MD</p> | |
| <p>CAUSE OF DEATH</p> <p>Heart Disease</p> | | <p>IMMEDIATE CAUSE</p> <p>Myocardial Infarction</p> | |
| <p>INTERVIEWED</p> <p>Yes</p> | | <p>DATE OF INTERVIEW</p> <p>3-3-37</p> | |
| <p>SIGNATURE OF PHYSICIAN</p> <p>[Signature]</p> | | <p>SIGNATURE OF REGISTRAR</p> <p>[Signature]</p> | |
| <p>DATE OF SIGNATURE</p> <p>3-3-37</p> | | <p>DATE OF SIGNATURE</p> <p>3-3-37</p> | |

3488

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE _____ b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ANDREWS AIR FORCE BASE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>WASHINGTON D.C.</u> <u>47X-3</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>USAF HOSPITAL, ANDREWS</u> | | | | d. STREET ADDRESS
<u>1200 DELAWARE AVE SW</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>N/B</u> Middle <u>JOHNSON</u> Last _____ | | | | 4. DATE OF DEATH
Month <u>MARCH</u> Day <u>26</u> Year <u>1959</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>NEG</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>24 MARCH 59</u> | 9. AGE (In years last birthday) yrs.
<u>7</u> | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>N/A</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>N/A</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>HERMAN JOHNSON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>HARRYETTE YVONNE CARSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>N/A</u> | | 16. SOCIAL SECURITY NO.
<u>N/A</u> | | 17. INFORMATION
Address <u>WASHINGTON</u>
<u>HERMAN JOHNSON 1200 DELAWARE AVE SW</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity</u>
<u>776X</u>
DUE TO _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO _____
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Hour _____ a. m. _____ p. m. _____
Month _____ Day _____ Year <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | | (County) | (State) | |
| 21. I certify that I attended the deceased from <u>25 MAR</u> , 19 <u>59</u> , to <u>26 MAR</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2000 25 MAR</u> , 19 <u>59</u> , and that death occurred at <u>0430 M</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>USAF HOSPITAL Andrews</u>
DATE SIGNED <u>26 MAR 59</u> | | | | | | | |
| ACTUAL SIGNATURE <u>David I. Smith</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>DAVID I. SMITH CAPTAIN USAF (MC)</u> <u>USAF HOSPITAL ANDREWS, WASHINGTON 25 DC</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Buried</u> | 22b. DATE THEREOF
<u>3/31/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington (Ft. Myer) Va.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Winston Jenkins</u> | | | ADDRESS
<u>4804 Ga Ave</u> | | 24a. REC'D BY REGISTRAR
DATE <u>APR 2 '59</u> | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thoma</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 12, 13, 14, 15 Film 239 3-16-59 et

3444

CERTIFICATE OF DEATH

03450

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince George
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
1 Day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince George General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Oliver | | 4. DATE OF DEATH
Mar. 8 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb 24, 1881 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Washington, D. C. |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service
No. | | 17. INFORMANT
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebellar Thrombosis secondary to occlusion of the Basilar artery.
332 x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis
DUE TO (c) Generalized Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours. years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 21. I certify that I attended the deceased from Mar. 7 19 59 , to Mar. 8 19 59 , that I last saw the deceased alive on Mar. 8 19 59 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. | | 20f. (City or town) (County) (State) | |
| ACTUAL SIGNATURE
Albert Roth | | ADDRESS (Street, city or town, state)
Annapolis, Md. | |
| PHYSICIAN'S NAME (Type)
Dr. Albert Roth | | DATE
3-9-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
3-9-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Campbell Funeral Home | | 22d. LOCATION (City, town, or county) (State)
443 M. St. N.W. Wash, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch Sons Hyattsville, Md. | | 24a. REC'D BY REGISTRAR
MAR 11 1959 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Howard | |

MEDICAL CERTIFICATION

2

77

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------------------------------|--|------------------------------------------------|--|
| <p>1. Name of deceased: <u>John Doe</u></p> | | <p>2. Date of death: <u>1945</u></p> | |
| <p>3. Age at death: <u>45</u></p> | | <p>4. Sex: <u>Male</u></p> | |
| <p>5. Race: <u>White</u></p> | | <p>6. Marital status: <u>Married</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | | <p>8. Place of death: <u>Home</u></p> | |
| <p>9. Date of birth: <u>1900</u></p> | | <p>10. Date of death: <u>1945</u></p> | |
| <p>11. Name of physician: <u>Dr. Smith</u></p> | | <p>12. Name of funeral home: <u>None</u></p> | |
| <p>13. Name of informant: <u>John Doe</u></p> | | <p>14. Name of informant: <u>John Doe</u></p> | |
| <p>15. Name of informant: <u>John Doe</u></p> | | <p>16. Name of informant: <u>John Doe</u></p> | |
| <p>17. Name of informant: <u>John Doe</u></p> | | <p>18. Name of informant: <u>John Doe</u></p> | |
| <p>19. Name of informant: <u>John Doe</u></p> | | <p>20. Name of informant: <u>John Doe</u></p> | |
| <p>21. Name of informant: <u>John Doe</u></p> | | <p>22. Name of informant: <u>John Doe</u></p> | |
| <p>23. Name of informant: <u>John Doe</u></p> | | <p>24. Name of informant: <u>John Doe</u></p> | |
| <p>25. Name of informant: <u>John Doe</u></p> | | <p>26. Name of informant: <u>John Doe</u></p> | |
| <p>27. Name of informant: <u>John Doe</u></p> | | <p>28. Name of informant: <u>John Doe</u></p> | |
| <p>29. Name of informant: <u>John Doe</u></p> | | <p>30. Name of informant: <u>John Doe</u></p> | |
| <p>31. Name of informant: <u>John Doe</u></p> | | <p>32. Name of informant: <u>John Doe</u></p> | |
| <p>33. Name of informant: <u>John Doe</u></p> | | <p>34. Name of informant: <u>John Doe</u></p> | |
| <p>35. Name of informant: <u>John Doe</u></p> | | <p>36. Name of informant: <u>John Doe</u></p> | |
| <p>37. Name of informant: <u>John Doe</u></p> | | <p>38. Name of informant: <u>John Doe</u></p> | |
| <p>39. Name of informant: <u>John Doe</u></p> | | <p>40. Name of informant: <u>John Doe</u></p> | |
| <p>41. Name of informant: <u>John Doe</u></p> | | <p>42. Name of informant: <u>John Doe</u></p> | |
| <p>43. Name of informant: <u>John Doe</u></p> | | <p>44. Name of informant: <u>John Doe</u></p> | |
| <p>45. Name of informant: <u>John Doe</u></p> | | <p>46. Name of informant: <u>John Doe</u></p> | |
| <p>47. Name of informant: <u>John Doe</u></p> | | <p>48. Name of informant: <u>John Doe</u></p> | |
| <p>49. Name of informant: <u>John Doe</u></p> | | <p>50. Name of informant: <u>John Doe</u></p> | |
| <p>51. Name of informant: <u>John Doe</u></p> | | <p>52. Name of informant: <u>John Doe</u></p> | |
| <p>53. Name of informant: <u>John Doe</u></p> | | <p>54. Name of informant: <u>John Doe</u></p> | |
| <p>55. Name of informant: <u>John Doe</u></p> | | <p>56. Name of informant: <u>John Doe</u></p> | |
| <p>57. Name of informant: <u>John Doe</u></p> | | <p>58. Name of informant: <u>John Doe</u></p> | |
| <p>59. Name of informant: <u>John Doe</u></p> | | <p>60. Name of informant: <u>John Doe</u></p> | |
| <p>61. Name of informant: <u>John Doe</u></p> | | <p>62. Name of informant: <u>John Doe</u></p> | |
| <p>63. Name of informant: <u>John Doe</u></p> | | <p>64. Name of informant: <u>John Doe</u></p> | |
| <p>65. Name of informant: <u>John Doe</u></p> | | <p>66. Name of informant: <u>John Doe</u></p> | |
| <p>67. Name of informant: <u>John Doe</u></p> | | <p>68. Name of informant: <u>John Doe</u></p> | |
| <p>69. Name of informant: <u>John Doe</u></p> | | <p>70. Name of informant: <u>John Doe</u></p> | |
| <p>71. Name of informant: <u>John Doe</u></p> | | <p>72. Name of informant: <u>John Doe</u></p> | |
| <p>73. Name of informant: <u>John Doe</u></p> | | <p>74. Name of informant: <u>John Doe</u></p> | |
| <p>75. Name of informant: <u>John Doe</u></p> | | <p>76. Name of informant: <u>John Doe</u></p> | |
| <p>77. Name of informant: <u>John Doe</u></p> | | <p>78. Name of informant: <u>John Doe</u></p> | |
| <p>79. Name of informant: <u>John Doe</u></p> | | <p>80. Name of informant: <u>John Doe</u></p> | |
| <p>81. Name of informant: <u>John Doe</u></p> | | <p>82. Name of informant: <u>John Doe</u></p> | |
| <p>83. Name of informant: <u>John Doe</u></p> | | <p>84. Name of informant: <u>John Doe</u></p> | |
| <p>85. Name of informant: <u>John Doe</u></p> | | <p>86. Name of informant: <u>John Doe</u></p> | |
| <p>87. Name of informant: <u>John Doe</u></p> | | <p>88. Name of informant: <u>John Doe</u></p> | |
| <p>89. Name of informant: <u>John Doe</u></p> | | <p>90. Name of informant: <u>John Doe</u></p> | |
| <p>91. Name of informant: <u>John Doe</u></p> | | <p>92. Name of informant: <u>John Doe</u></p> | |
| <p>93. Name of informant: <u>John Doe</u></p> | | <p>94. Name of informant: <u>John Doe</u></p> | |
| <p>95. Name of informant: <u>John Doe</u></p> | | <p>96. Name of informant: <u>John Doe</u></p> | |
| <p>97. Name of informant: <u>John Doe</u></p> | | <p>98. Name of informant: <u>John Doe</u></p> | |
| <p>99. Name of informant: <u>John Doe</u></p> | | <p>100. Name of informant: <u>John Doe</u></p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03451

3445

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
Maryland Prince George MARYLAND | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | | c. LENGTH OF STAY IN 1b
9 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) David Thomas Jones | | | | 4. DATE OF DEATH
Month March Day 24 Year 1959 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 29, 1888 | | 9. AGE (In years last birthday)
71 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home Construction self-employed | | 11. BIRTHPLACE (State or foreign country)
South Wales, England | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
(Unknown) Jones | | | | 14. MOTHER'S MAIDEN NAME
Sara (UNKNOWN) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) No (If yes, give war or dates of service) None | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Mrs. Minnie Hodiak, 4800 Somerset Rd. Riverdale, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulm. edema
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic HT dis.
DUE TO (c) Adeno carcinoma of the lungs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 15 Mar , 19 59 , to 24 MAR , 19 59 , that I last saw the deceased alive on 24 Mar , 19 59 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
John Bayly | | | | ADDRESS (Street, city or town, state)
1835 Eye N.W. WASH DC. | | | |
| PHYSICIAN'S NAME (Type)
Dr. John Bayly | | | | DATE SIGNED
15 Mar 59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/28/1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Colmar Manor, Pr. Geo. Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Company, Riverdale, Md. | | | | 24a. REC'D BY REGISTRAR
DATE MAR 30 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hous | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3446

CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH
o. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
West Hyattsville | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | | | d. STREET ADDRESS
5608 Queens Chapel Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First RENA Middle JANE Last KING | | 4. DATE OF DEATH
Month March Day 6 Year 1959 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 22nd, 1876 | | 9. AGE (In years last birthday)
82 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
At home | | 11. BIRTHPLACE (State or foreign country)
Stafford County, Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Enoch Skidmore | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Florence L. Mercilllott, 5608 Queens Chapel Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ac Coronary Occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3-4 min. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Congestive Heart Disease | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1957 , to March 6, 1959 , that I last saw the deceased alive on March 3, 1959 , and that death occurred at 5:50 p. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Bernard Katzen M.D. 3550 - Manna Ave. - J.E. | | | | | | | |
| PHYSICIAN'S NAME (Type) BERNARD KATZEN M.D. 3550 - Manna Ave. - J.E. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
March 10, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Nat'l Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Falls Church, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Company, Riverdale, Md. | | | | 24a. REC'D BY REGISTRAR
MAR 10 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Huns | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------------------------------------|--|-------------------------------------------------------|--|
| <p>1. Name of deceased: <u>JOHN J. BROWN</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>10-15-1890</u></p> | | <p>4. Place of birth: <u>MASSACHUSETTS</u></p> | |
| <p>5. Date of death: <u>10-25-1960</u></p> | | <p>6. Place of death: <u>At home</u></p> | |
| <p>7. Cause of death: <u>Heart disease</u></p> | | <p>8. Manner of death: <u>Natural</u></p> | |
| <p>9. Signature of physician: <u>[Signature]</u></p> | | <p>10. Signature of registrar: <u>[Signature]</u></p> | |
| <p>11. Date of filing: <u>10-26-1960</u></p> | | <p>12. Office of filing: <u>Boston</u></p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03453

3447

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

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| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheverly</u> | | c. LENGTH OF STAY IN 1b
<u>209</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>15 Hyattsville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Prince Georges San Hosp</u> | | | d. STREET ADDRESS
<u>1806 - Fox Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
<u>John Joseph Langan</u> | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>4</u> Year <u>1959</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-16-99</u> | 9. AGE (In years last birthday)
<u>59</u> yrs. | IF UNDER 1 YEAR
Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
<u>Secretary-treasurer Catholic Int. Union</u> | | | 11. BIRTHPLACE (State or foreign country)
<u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>James Langan</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Leeson</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)
<u>No.</u> | | 16. SOCIAL SECURITY NO.
<u>W.W.1</u> | | 17. INFORMANT
<u>Mary Langan - Same address as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>acute congestive heart failure</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u>
(a), stating the underlying cause last. DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Yonkers</u> | |
| 20f. (City or town)
<u>Yonkers</u> | | 20g. (County)
<u>N.Y.</u> | | 20h. (State)
<u>N.Y.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
<u>John J. Maloney</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
<u>March 4, 1959</u> | |
| EXAMINER'S NAME (Type)
<u>John T. Maloney, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>MAR 7, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ST. Joseph's</u> | |
| 22d. LOCATION (City, town, or county)
<u>Yonkers</u> | | 22e. (State)
<u>N.Y.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W.W. Lattimer</u> | | ADDRESS
<u>3603 14th St NW</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAR 6 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kane</u> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR WIFE
MILAN DEPT

3847

(DATE OF CASE)
1917

DEATH CERTIFICATE

1917

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]

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3448

CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Capitol Heights | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Chesley Prince George General Hospital | | | | e. STREET ADDRESS 1425 60th Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Peter First Lanham Middle Lanham | | | | 4. DATE OF DEATH Mar. Month 28 Day 19 Year 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 14, 1959 | |
| 9. AGE (In years last birthday) 24 yrs. | | IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Richard Lanham | | | | 14. MOTHER'S MAIDEN NAME Eva Riddle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Mother, Eva Lanham Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal Obstruction and Gangrene of Bowel
756.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Volvulus of ascending colon and terminal Ileum
DUE TO (c) Meekles Diverticulum
INTERVAL BETWEEN ONSET AND DEATH 12 hours.
2 hours
since birth | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar. 14 , 19 59 , to Mar. 28 , 19 59 , that I last saw the deceased alive on Mar. 14 , 19 59 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Max M. Herzberg | | | | ADDRESS (Street, city or town, state) 7016 Grey St., Seat Pleasant Md. | | | |
| PHYSICIAN'S NAME (Type) Max Herzberg, M.D. | | | | DATE SIGNED 3/29/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 4/1/59 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Suitland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 517 11th St. | | | | 24a. REC'D BY REGISTRAR APR 1 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kruze | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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3449

CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheverly</u> | | | | c. LENGTH OF STAY IN 1b
<u>26 hours</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Prince Georges General Hospital</u> | | | | d. STREET ADDRESS
<u>9052 Rhode Island Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>Doris</u> | | First Middle Last
<u>Longanecker</u> | | 4. DATE OF DEATH
Month <u>March</u> Day <u>20</u> Year <u>19 59</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/22/04</u> | 9. AGE (In years last birthday)
<u>54</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>England</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>United States</u> | |
| 13. FATHER'S NAME
<u>John Dobson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Hutchinson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>Walter Husband</u> | | Address
<u>Address same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Menengitis Meningitis</u>
<u>057.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Sept. 15</u> , 19 <u>45</u> , to <u>3/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>59</u> , and that death occurred at <u>11:50 AM</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>C. Louis Mendel</u> M.D. <u>4506 COLLEGE AVE</u> <u>3/21/59</u>
PHYSICIAN'S NAME (Type) <u>Dr. Mendel, C. LOUIS</u> <u>COLLEGE PARK MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>March 21, 1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) _____ (State) _____
<u>Colmar Manor, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>F. Gasch's Sons</u> | | | | ADDRESS
<u>Hyattsville Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAR 24 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03456

3450

| | | | | | | | |
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| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chesley | | c. LENGTH OF STAY IN 1b
13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lanham | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | | | d. STREET ADDRESS
6009 Naval Avenue | | | |
| 3. NAME OF DECEASED (Type or print)
First Peter Middle J Last Lynch | | | | 4. DATE OF DEATH
Month March Day 5 Year 19 59 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/23/71 | | 9. AGE (In years last birthday)
87 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Builder-Contractor | | 11. BIRTHPLACE (State or foreign country)
Carroll, Iowa | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
Patrick Lynch | | | | 14. MOTHER'S MAIDEN NAME
Ann Wilkins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Edward P Lynch Son Address Same, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli
585X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cholecystitis DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH
48 hours
11 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 5, 1959 to March 5, 1959 , that I last saw the deceased alive on March 5, 1959 , and that death occurred at 5:47P M, from the causes and on the date stated above.
ACTUAL SIGNATURE Thomas G Maloney M.D. 4814-11st Ave Lanham Md 20626 DATE SIGNED 6/1/59
PHYSICIAN'S NAME (Type) Dr. Thomas G. Maloney | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/9/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Grundy Center, Iowa | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Nalley's Funeral Home Mt Rainier Md | | | | ADDRESS
2nd | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3412

CERTIFICATE OF DEATH

03457

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>Va.</u> b. COUNTY <u>83X-3</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Backlick Springfield</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u> | | d. STREET ADDRESS <u>Rt 2 Box 294 Backlick Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MISS ANNA</u> Middle <u>R</u> Last <u>MALEY</u> | | 4. DATE OF DEATH Month <u>MAR</u> Day <u>15</u> Year <u>1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/20/1881</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Justin Malley</u> | | 14. MOTHER'S MAIDEN NAME <u>Julia Malley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Dolores Malley</u> Address <u>6915 Dunmanway Balt. Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>331X Respiratory Depression</u>
DUE TO <u>Cerebral Hemorrhage</u>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Hypertension arteriosclerosis</u>
(c) <u>Years</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>now</u> , 19 <u>58</u> , to <u>March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 12</u> , 19 <u>59</u> , and that death occurred at <u>8:42</u> M, from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <u>511567</u> | | DATE SIGNED <u>5/15/59</u> | |
| ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D. | | 4323 Havard St. Silver Spring, Md. | |
| PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u> | | 4323 Havard St. Silver Spring, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>3/17/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u> | 22d. LOCATION (City, town, or county) (State) <u>Wheeling West Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawless Sons</u> ADDRESS <u>1756 PA Ave. N.W.</u> | | 24. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | |

CERTIFICATE OF DEATH

03458

Reg. Dist. No.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY PRINCE GEO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL MD | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 411 LAUREL AVE | | d. STREET ADDRESS 411 LAUREL AVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First MARIA Middle P. Last MARKS | | 4. DATE OF DEATH MAR DEC 1959 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC 11, 1871 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY MD | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME SAMUEL WATTS | | 14. MOTHER'S MAIDEN NAME JULIA ANDERSON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Elsie Marks 411 Laurel Ave Laurel | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertension - Hypertensive Heart Disease
420.1 DUE TO Coronary Thrombosis -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- (c) --- | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --- | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 P.M. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7/18 , 19 56 , to 3-6 , 19 59 , that I last saw the deceased alive on 3-6 , 19 59 , and that death occurred at 8:30 P.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE N B STEWARD | | DATE SIGNED 3/2/59 | |
| PHYSICIAN'S NAME (Type) N B STEWARD | | ADDRESS (Street, city or town, state) 314 Compton Ave Laurel MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Mar 8 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ivy Hill | | 22d. LOCATION (City, town, or county) (State) Laurel MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ridgely Selby 1200 Snowden Rd Laurel MD | | 24a. REC'D BY REGISTRAR --- DATE MAR 10 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | | | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03459

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE New York b. COUNTY New York | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | c. LENGTH OF STAY IN 1b 3 hours | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69X-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | d. STREET ADDRESS 2132 Gleason Avenue | |
| 3. NAME OF DECEASED (Type or print) Matthew McCormack | | 4. DATE OF DEATH March 16, 1959 | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-11-1892 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Bus driver | 11. BIRTHPLACE (State or foreign country) Ireland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Patrick McCormack | |
| 14. MOTHER'S MAIDEN NAME Mary Ann Fay | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 1 | |
| 16. SOCIAL SECURITY NO. 088-07-0371 | | 17. INFORMANT Bridgit McCormack; same address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 812X DUE TO aHemorrhage and shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of branches of Pudendal artery
(c) Fractured pelvis. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rupture of diaphragm with herniation of stomach and intestines. | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A pedestrian, struck by an automobile. | |
| 20c. TIME OF INJURY Month, Day, Year 7.18 3-15-1959 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | 20f. (City or town) (County) (State) College Park, Pr. Geo. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney | | DATE SIGNED March 16, 1959 | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/20/59 | 22c. NAME OF CEMETERY OR CREMATORY St. Raymond Cemetery | 22d. LOCATION (City, town, or county) (State) New York Pine Lawn, New York |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | 24a. REC'D BY REGISTRAR MAR 19 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur E. Kiser | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the cause should be stated in the certificate. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department. Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
15M 10/57

20077262XVJ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3453

CERTIFICATE OF DEATH

03460

Reg. Dist. No.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b 1
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park Hyattsville
d. STREET ADDRESS 8244 14th Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Baby Boy Mc Gown
First Mo Gown Middle Last | | | | 4. DATE OF DEATH
Month Mar. Day 28 Year 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 23, 1959 | |
| 9. AGE (In years last birthday) yrs. 22 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Rae Mc Gown | | | | 14. MOTHER'S MAIDEN NAME Jeanne Marie Goudie | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mother, Jeanne Mc Gown, Same
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
762.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolism
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Mar. 23 , 19 59 , to Mar. 26 , 19 59 , that I last saw the deceased alive on Mar. 26 , 19 59 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE C. Louis Mendel M.D. | | | | ADDRESS (Street, city or town, state) 4506 COLLEGE AVE | | DATE SIGNED 3/26/59 | |
| PHYSICIAN'S NAME (Type) C. LOUIS MENDEL | | | | COLLEGE PARK Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) cremation | | 22b. DATE THEREOF 3/31/59 | | 22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Pa. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr
ADDRESS Administrator. | | | | 24a. REC'D BY REGISTRAR APR 6 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

CERTIFICATE OF DEATH

1923

8

John Thomas
C. Jones Menor
the same as
M. J.

1 77 3454 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 8 Film G240 3-30-59 et CERTIFICATE OF DEATH 03461 Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN-1b
2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | f. STREET ADDRESS
3713 43rd Ave. | |
| 3. NAME OF DECEASED (Type or print)
John McKeller | | 4. DATE OF DEATH
Month March Day 16 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1894 25 Sept. 1895 |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Hungary | |
| 11. BIRTHPLACE (State or foreign country)
Hungary | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Jones Mikheller | | 14. MOTHER'S MAIDEN NAME
Anna Wolf | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
58778 10 7246 | |
| 17. INFORMANT
Earle McKellar | | Address
5E Parkway Rd, Greenbelt Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute C.V. A
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
3-5-59 |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-5 , 19 59 , to 3-16 , 19 59 , that I last saw the deceased alive on 3-16 , 19 59 , and that death occurred at 6.15 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
George Hageage | | ADDRESS (Street, city or town, state)
3717-38th Ave | |
| PHYSICIAN'S NAME (Type)
Dr. G. Hageage, M.D. | | DATE SIGNED
3-16-59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
March 18, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | ADDRESS
Hyattsville Md. | |
| 24a. REC'D BY REGISTRAR
MAR 23 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|
| NAME OF DECEASED
[Faint text, possibly "JOHN J. ..."] | | PLACE OF BIRTH
[Faint text, possibly "NEW YORK, N.Y."] | |
| SEX
[Faint text, possibly "Male"] | | DATE OF BIRTH
[Faint text, possibly "1900-01-01"] | |
| OCCUPATION
[Faint text, possibly "Carpenter"] | | CAUSE OF DEATH
[Faint text, possibly "Heart Disease"] | |
| PLACE OF DEATH
[Faint text, possibly "Home"] | | DATE OF DEATH
[Faint text, possibly "1950-03-15"] | |
| TIME OF DEATH
[Faint text, possibly "10:00 AM"] | | SIGNATURE OF PHYSICIAN
[Faint signature] | |
| SIGNATURE OF REGISTRAR
[Faint signature] | | SIGNATURE OF WITNESS
[Faint signature] | |
| CERTIFICATE OF DEATH
[Faint text, possibly "This is to certify that the above named person died on the date and at the place stated above..."] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G241, 4/15/59 fey

CERTIFICATE OF DEATH

03462

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
cheverly | | c. LENGTH OF STAY IN 1b
22 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Julia Middle E Last Marryman | | 4. DATE OF DEATH
Month March Day 15 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/11/84 |
| 9. AGE (In years last birthday)
75 74 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Virginia | |
| 11. BIRTHPLACE (State or foreign country)
United States | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
John Simpson | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Agnes Wooten Grand daughter Hillside Md. | | Address 1209 56 Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Conge. Hem + Edema
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Inf.
DUE TO (c) Acc. to the Ant. disc. found at the Aut. exam.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from February 21 , 19 59 , to March 15 , 19 59 , that I last saw the deceased alive on March 15 , 19 59 , and that death occurred at 6:25P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Peter Duus | | M.D. 6124 Central Av. | |
| PHYSICIAN'S NAME (Type)
Dr. Peter Duus M.D. | | ADDRESS (Street, city or town, state)
Capitol Heights, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3-18-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 22d. LOCATION (City, town, or county) (State)
Shutland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert A. Mattingly | | ADDRESS 131-11 St. D.C. | |
| 24a. REC'D BY REGISTRAR
Mar 18 59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraw | |

3489

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland
b. COUNTY Baltimore ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi - Rural | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. 3401-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paint Branch Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Leroy - Miller | | | | 4. DATE OF DEATH Month Day Year Mar. 9 1959 | | | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 20 1898 | | 9. AGE (In years last birthday) 60 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore Gas & Electric Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | |
| 13. FATHER'S NAME George A. Miller | | | | 14. MOTHER'S MAIDEN NAME Jane G. Mathews | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 212-65-0717 | | 17. INFORMANT Address Nursing Home Records, - Adelphi Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Degeneration DUE TO 1 year
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 30 min | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from April 18, 1958, to March 9, 1959, that I last saw the deceased alive on Jan 14, 1959, and that death occurred at 2:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Merrill M. Cross M.D. | | | | ADDRESS (Street, city or town, state) 8248 Georgia Ave. | | DATE SIGNED 3/9/59 | |
| PHYSICIAN'S NAME (Type) MERRILL M. CROSS MD. | | | | Silver Spring, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/12/59 | | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore Street | | | | 24a. REC'D BY REGISTRAR DATE MAR 12 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanna | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3456

CERTIFICATE OF DEATH

03464

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge 27 13X-2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hospital</u> | | | | d. STREET ADDRESS <u>6726 Washington Blvd.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew P. O'Connor</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1959</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 17, 1869</u> | 9. AGE (In years last birthday) <u>89</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper - Writer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPERS</u> | | 11. BIRTHPLACE (State or foreign country) <u>Minnesota</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Maurice C. O'Connor</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Honora E. Martin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u> | | 17. INFORMANT Address <u>Baltimore, Md. 730 Hildworth Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u>
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from <u>2-5</u> , 19 <u>59</u> , to <u>3-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-10</u> , 19 <u>59</u> , and that death occurred at <u>4:00 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>D. R. Purdie</u> | | M.D. <u>4409 QUEENS BRY. RD. RIVERDALE, MD.</u> | | ADDRESS (Street, city or town, state) <u>3-10 59</u> | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>D. R. PURDIE</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>3-14-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>DeVal Funeral Home</u> | | ADDRESS <u>Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR <u>DATE MAR 17 59</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 241 4-6-59 et

CERTIFICATE OF DEATH

03465

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY <i>Prince Georges</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Md.</i> b. COUNTY <i>Prince Georges</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Decatur Heights</i> | | c. LENGTH OF STAY IN 1b <i>23 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5203 Upshuns ST.</i> | | d. STREET ADDRESS <i>5203 Upshun ST.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM FRANCIS OWENS</i> | | 4. DATE OF DEATH Month Day Year <i>MARCH 31 1959</i> | |
| 5. SEX <i>MALE</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov. 9, 1890</i> |
| 9. AGE (In years lost birthday) <i>68 6/9</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <i>Retired Supt.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Long Horn Bldg</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Ponts mouth VA.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>William F. Owens</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Schmidt</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT <i>WIFE</i> Address <i>Mrs Mary Owens</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>CORONARY Thrombosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>JAN</i> , 1957, to <i>MARCH 31</i> , 1959, that I last saw the deceased alive on <i>MARCH 31</i> , 1959, and that death occurred at <i>7:15 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Norman Donat Comeau</i> M.D. | | ADDRESS (Street, city or town, state) <i>3503 Penny ST</i> DATE SIGNED <i>3/31/59</i> | |
| PHYSICIAN'S NAME (Type) <i>NORMAN DONAT COMEAU</i> | | <i>MT. RAINIER MD</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>4/2/59</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i> | | 22d. LOCATION (City, town, or county) (State) <i>Colmar Manor Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> | | 24a. REC'D BY REGISTRAR DATE <i>APR 2 '59</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i> | | | |

CERTIFICATE OF DEATH

1938

NAME OF DECEASED: *William J. Smith*
AGE: *42* YEARS
SEX: *Male*
RACE: *White*
DATE OF DEATH: *April 15, 1938*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
DISEASE OR INJURY: *Coronary Artery Disease*
PERIOD OF ILLNESS: *Several weeks*
PLACE OF BIRTH: *Baltimore, Md.*
DATE OF BIRTH: *March 10, 1896*
MARRIED: *Yes*
OCCUPATION: *Engineer*
EDUCATION: *High School*
RELIGION: *Methodist*
MANNER OF DEATH: *Natural*
DECEASED'S SIGNATURE: *William J. Smith*
WITNESSES' SIGNATURES: *John Doe, Jane Doe*
DECEASED'S ADDRESS: *123 Main St., Baltimore, Md.*
DECEASED'S PHONE: *1234*
DECEASED'S SOCIAL SECURITY NUMBER: *123-45-6789*

DECEASED'S SIGNATURE: *William J. Smith*
WITNESSES' SIGNATURES: *John Doe, Jane Doe*
DECEASED'S ADDRESS: *123 Main St., Baltimore, Md.*
DECEASED'S PHONE: *1234*
DECEASED'S SOCIAL SECURITY NUMBER: *123-45-6789*
DECEASED'S MARITAL STATUS: *Married*
DECEASED'S OCCUPATION: *Engineer*
DECEASED'S EDUCATION: *High School*
DECEASED'S RELIGION: *Methodist*
DECEASED'S MANNER OF DEATH: *Natural*
DECEASED'S PERIOD OF ILLNESS: *Several weeks*
DECEASED'S DISEASE OR INJURY: *Coronary Artery Disease*
DECEASED'S CAUSE OF DEATH: *Heart Disease*
DECEASED'S PLACE OF DEATH: *Home*
DECEASED'S DATE OF DEATH: *April 15, 1938*
DECEASED'S AGE: *42* YEARS
DECEASED'S SEX: *Male*
DECEASED'S RACE: *White*
DECEASED'S NAME: *William J. Smith*

3413

CERTIFICATE OF DEATH

03466

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town)
Hyattsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
3915 Madison Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Alfred Middle Pasek Last Pasek | | 4. DATE OF DEATH
Month Mar Day 12 Year 1959 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/27/1908 |
| 9. AGE (In years last birthday)
50 yrs. | | 10. IF UNDER 1 YEAR
Months 3 Days 12 | 11. IF UNDER 24 HRS.
Hours 12 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steamfitter | | 10b. KIND OF BUSINESS OR INDUSTRY
D.C. Water Dept. | |
| 11. BIRTHPLACE (State or foreign country)
Kansas | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
James Pasek | | 14. MOTHER'S MAIDEN NAME
Jennie Zajic | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16. SOCIAL SECURITY NO.
514-07-7029 | |
| 17. INFORMANT
Mrs. Alfred Pasek | | 18. ADDRESS
3915 Madison Street Hyattsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Primary Carcinoma (Pulmonary)
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1949 to date , 19 59 , that I last saw the deceased alive on 9 May 59 , 19 59 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1746 - K - ST. N.W. 12 Mar 59
DATE SIGNED
ACTUAL SIGNATURE C. P. REEVES M.D.
PHYSICIAN'S NAME (Type) C. P. REEVES | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
3/16/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory Prince Georges County, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S. H. Hines Co. | | 24a. REC'D BY REGISTRAR
MAR 16 1959 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | 24c. ADDRESS
2901 11th St., N.W. Washington 9, D.C. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03468

Reg. Dist. No.

3457

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> PRINCE GEORGE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Chesley</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Beltsville (General Delivery)</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Prince George General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Ralph Ivan Poole</u> | | | | 4. DATE OF DEATH <u>Mar.</u> <u>17</u> <u>1959</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 10, 1958</u> | |
| 9. AGE (In years last birthday) yrs. <u>6</u> | | IF UNDER 1 YEAR Months <u>6</u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None--Infant</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Goshen, Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Frank Pool 111</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Rachel Ann Ingram</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>None</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>Frank I. Poole, 111, General Del. Beltsville, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adrenal failure.</u>
<u>455X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemorrhagic mesencephalic bleed.</u>
DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. <u>19</u>
p. m. <u></u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u>Suitland, Pr. Geo. Co., Md.</u> | | | | (County) <u></u> (State) <u></u> | | | |
| 21. I certify that I attended the deceased from <u>Mar. 17, 1959</u> to <u>Mar. 17, 1959</u> , that I last saw the deceased alive on <u>Mar. 17, 1959</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John W. Puck</u> | | | | ADDRESS (Street, city or town, state) <u>5301 Hamlet St., Hyattsville, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>John W. Puck</u> | | | | DATE SIGNED <u>3/18/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>March 20/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Washington Nat'l Com.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Suitland, Pr. Geo. Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W.W. Chambers Company, Riverdale, Md.</u> | | | | 24a. REC'D BY REGISTRAR
<u>DATE MAR 20 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thoma</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar for use in burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|-------------------------------------------------------|--|----------------------------------------------------------|--|
| <p>1. Name of deceased: <i>John A. Smith</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of birth: <i>Jan. 1, 1880</i></p> | | <p>4. Place of birth: <i>St. Louis, Mo.</i></p> | |
| <p>5. Date of death: <i>Jan. 15, 1940</i></p> | | <p>6. Place of death: <i>St. Louis, Mo.</i></p> | |
| <p>7. Cause of death: <i>Heart disease</i></p> | | <p>8. Immediate cause: <i>Myocardial infarction</i></p> | |
| <p>9. Duration of illness: <i>2 weeks</i></p> | | <p>10. Name of physician: <i>Dr. J. H. Jones</i></p> | |
| <p>11. Name of informant: <i>John A. Smith</i></p> | | <p>12. Address: <i>1234 Main St., St. Louis, Mo.</i></p> | |
| <p>13. Signature of informant: <i>[Signature]</i></p> | | <p>14. Signature of physician: <i>[Signature]</i></p> | |

3414

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5619 Annapolis Road</u> | | d. STREET ADDRESS <u>5619-Annapolis Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Blanche A. Pouncey</u> | | 4. DATE OF DEATH <u>3/30</u> 19 <u>59</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/12/95</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Tom Henry Powe deceased</u> | | 14. MOTHER'S MAIDEN NAME <u>Betty Alice Crimigeur deceased</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>13-1116101</u> | |
| 17. INFORMANT <u>Marie Louise Marshall</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro Vascular accident</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Central atherosclerosis</u>
DUE TO
(c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA - 3 mos previous</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |

21. I certify that I attended the deceased from Sept 1958, to 30 Mar 1959, that I last saw the deceased alive on 28 Mar 1959, and that death occurred at _____ M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED 3/30/59

ACTUAL SIGNATURE John K. Kehoe M.D.
PHYSICIAN'S NAME (Type) JOHN KEHOE 3404-Cheverly Ave. Cheverly, Md.

| | | | |
|---------------------------------------------------------|---------------------------------|--------------------------------------------------------|------------------------------------------------------------------------|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4/2/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u> | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u> |
|---------------------------------------------------------|---------------------------------|--------------------------------------------------------|------------------------------------------------------------------------|

23. FUNERAL DIRECTOR'S SIGNATURE Mailey's Funeral Home ADDRESS mt. Rainier Md.
24. REC'D BY REGISTRAR ADD 3 1959 24b. REGISTRAR'S SIGNATURE Arthur L. Thoma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in the registration of the death. Pages 1 and 2 should be filed with the registrar for use in the registration of the death.

CERTIFICATE OF DEATH

| | | | |
|----------------------------------------------------------|--|----------------------------------------------------|--|
| <p>1. Name of Deceased: <u>John Doe</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Age: <u>45</u></p> | | <p>4. Date of Birth: <u>Jan 15, 1900</u></p> | |
| <p>5. Place of Birth: <u>Johns Hopkins</u></p> | | <p>6. Date of Death: <u>Jan 20, 1945</u></p> | |
| <p>7. Cause of Death: <u>Heart Disease</u></p> | | <p>8. Place of Death: <u>Home</u></p> | |
| <p>9. Signature of Physician: <u>Dr. J. H. Smith</u></p> | | <p>10. Signature of Registrar: <u>John Doe</u></p> | |
| <p>11. Date of Registration: <u>Jan 21, 1945</u></p> | | <p>12. Place of Registration: <u>Baltimore</u></p> | |
| <p>13. Name of Hospital: <u>Johns Hopkins</u></p> | | <p>14. Name of Doctor: <u>Dr. J. H. Smith</u></p> | |
| <p>15. Name of Nurse: <u>John Doe</u></p> | | <p>16. Name of Assistant: <u>John Doe</u></p> | |
| <p>17. Name of Attendant: <u>John Doe</u></p> | | <p>18. Name of Burial: <u>John Doe</u></p> | |
| <p>19. Name of Cemetery: <u>Johns Hopkins</u></p> | | <p>20. Name of Minister: <u>John Doe</u></p> | |
| <p>21. Name of Pastor: <u>John Doe</u></p> | | <p>22. Name of Minister: <u>John Doe</u></p> | |
| <p>23. Name of Minister: <u>John Doe</u></p> | | <p>24. Name of Minister: <u>John Doe</u></p> | |
| <p>25. Name of Minister: <u>John Doe</u></p> | | <p>26. Name of Minister: <u>John Doe</u></p> | |
| <p>27. Name of Minister: <u>John Doe</u></p> | | <p>28. Name of Minister: <u>John Doe</u></p> | |
| <p>29. Name of Minister: <u>John Doe</u></p> | | <p>30. Name of Minister: <u>John Doe</u></p> | |
| <p>31. Name of Minister: <u>John Doe</u></p> | | <p>32. Name of Minister: <u>John Doe</u></p> | |
| <p>33. Name of Minister: <u>John Doe</u></p> | | <p>34. Name of Minister: <u>John Doe</u></p> | |
| <p>35. Name of Minister: <u>John Doe</u></p> | | <p>36. Name of Minister: <u>John Doe</u></p> | |
| <p>37. Name of Minister: <u>John Doe</u></p> | | <p>38. Name of Minister: <u>John Doe</u></p> | |
| <p>39. Name of Minister: <u>John Doe</u></p> | | <p>40. Name of Minister: <u>John Doe</u></p> | |
| <p>41. Name of Minister: <u>John Doe</u></p> | | <p>42. Name of Minister: <u>John Doe</u></p> | |
| <p>43. Name of Minister: <u>John Doe</u></p> | | <p>44. Name of Minister: <u>John Doe</u></p> | |
| <p>45. Name of Minister: <u>John Doe</u></p> | | <p>46. Name of Minister: <u>John Doe</u></p> | |
| <p>47. Name of Minister: <u>John Doe</u></p> | | <p>48. Name of Minister: <u>John Doe</u></p> | |
| <p>49. Name of Minister: <u>John Doe</u></p> | | <p>50. Name of Minister: <u>John Doe</u></p> | |
| <p>51. Name of Minister: <u>John Doe</u></p> | | <p>52. Name of Minister: <u>John Doe</u></p> | |
| <p>53. Name of Minister: <u>John Doe</u></p> | | <p>54. Name of Minister: <u>John Doe</u></p> | |
| <p>55. Name of Minister: <u>John Doe</u></p> | | <p>56. Name of Minister: <u>John Doe</u></p> | |
| <p>57. Name of Minister: <u>John Doe</u></p> | | <p>58. Name of Minister: <u>John Doe</u></p> | |
| <p>59. Name of Minister: <u>John Doe</u></p> | | <p>60. Name of Minister: <u>John Doe</u></p> | |
| <p>61. Name of Minister: <u>John Doe</u></p> | | <p>62. Name of Minister: <u>John Doe</u></p> | |
| <p>63. Name of Minister: <u>John Doe</u></p> | | <p>64. Name of Minister: <u>John Doe</u></p> | |
| <p>65. Name of Minister: <u>John Doe</u></p> | | <p>66. Name of Minister: <u>John Doe</u></p> | |
| <p>67. Name of Minister: <u>John Doe</u></p> | | <p>68. Name of Minister: <u>John Doe</u></p> | |
| <p>69. Name of Minister: <u>John Doe</u></p> | | <p>70. Name of Minister: <u>John Doe</u></p> | |
| <p>71. Name of Minister: <u>John Doe</u></p> | | <p>72. Name of Minister: <u>John Doe</u></p> | |
| <p>73. Name of Minister: <u>John Doe</u></p> | | <p>74. Name of Minister: <u>John Doe</u></p> | |
| <p>75. Name of Minister: <u>John Doe</u></p> | | <p>76. Name of Minister: <u>John Doe</u></p> | |
| <p>77. Name of Minister: <u>John Doe</u></p> | | <p>78. Name of Minister: <u>John Doe</u></p> | |
| <p>79. Name of Minister: <u>John Doe</u></p> | | <p>80. Name of Minister: <u>John Doe</u></p> | |
| <p>81. Name of Minister: <u>John Doe</u></p> | | <p>82. Name of Minister: <u>John Doe</u></p> | |
| <p>83. Name of Minister: <u>John Doe</u></p> | | <p>84. Name of Minister: <u>John Doe</u></p> | |
| <p>85. Name of Minister: <u>John Doe</u></p> | | <p>86. Name of Minister: <u>John Doe</u></p> | |
| <p>87. Name of Minister: <u>John Doe</u></p> | | <p>88. Name of Minister: <u>John Doe</u></p> | |
| <p>89. Name of Minister: <u>John Doe</u></p> | | <p>90. Name of Minister: <u>John Doe</u></p> | |
| <p>91. Name of Minister: <u>John Doe</u></p> | | <p>92. Name of Minister: <u>John Doe</u></p> | |
| <p>93. Name of Minister: <u>John Doe</u></p> | | <p>94. Name of Minister: <u>John Doe</u></p> | |
| <p>95. Name of Minister: <u>John Doe</u></p> | | <p>96. Name of Minister: <u>John Doe</u></p> | |
| <p>97. Name of Minister: <u>John Doe</u></p> | | <p>98. Name of Minister: <u>John Doe</u></p> | |
| <p>99. Name of Minister: <u>John Doe</u></p> | | <p>100. Name of Minister: <u>John Doe</u></p> | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03470

3458

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D.C.
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN lb
D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | d. STREET ADDRESS
U.S.Soldier's Home | |
| 3. NAME OF DECEASED (Type or print)
Pierce G. Quinn | | 4. DATE OF DEATH
Month March Day 30 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-1-82 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Watchman | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Lithuania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unk. | | 14. MOTHER'S MAIDEN NAME
Unk. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
Unk. | |
| 17. INFORMANT
Records of St Elizabeth's Hospital & Home | | Address
Soldier's | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Toxemia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute pneumonitis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cardiovascular renal disease and aortic aneurism. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | DATE SIGNED
March 30, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4/1/59 | 22c. NAME OF CEMETERY OR CREMATORY
Soldier Home National Cemo. | 22d. LOCATION (City, town, or county) (State)
Washington D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | ADDRESS
Hyattsville, Md. | |
| 24a. REC'D BY REGISTRAR
APR 1 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kline | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|---------------------------------------------------|--|
| Name of Deceased | | John J. Lantry, Jr. | |
| Age | | 35 | |
| Sex | | Male | |
| Race | | White | |
| Date of Death | | March 20, 1935 | |
| Place of Death | | Baltimore, Maryland | |
| Cause of Death | | Hepatic failure, secondary to chronic alcoholism. | |
| Manner of Death | | Alcoholism | |
| Signature of Medical Examiner | | [Signature] | |
| Signature of Coroner | | [Signature] | |
| Signature of Registrar | | [Signature] | |

CERTIFICATE OF DEATH

3491

Reg. Dist. No.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE D. C. b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | |
| c. LENGTH OF STAY IN 1b 2 months & 8 days | | d. STREET ADDRESS 9th & N.Y. Ave., N.W. (Hotel) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lucy Middle M. Last Ramsey | | 4. DATE OF DEATH Month 3 Day 10 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/6/21 |
| 9. AGE (In years last birthday) 37 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress (3 yrs., ago) | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles L. Palmer | | 14. MOTHER'S MAIDEN NAME Katie Petty | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - | | 16. SOCIAL SECURITY NO. 225-28-6188 | |
| 17. INFORMANT Decedent | | Address - | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary hemorrhage
002X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary tuberculosis
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
10 minutes
4 years, 2 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes mellitus | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 1/2/1959, to 3/10/1959, that I last saw the deceased alive on 3/10/1959, and that death occurred at 6:04 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Moe Weiss | | ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 3/10/59 | |
| PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | Glenn Dale, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3-13-1959 | 22c. NAME OF CEMETERY OR CREMATORY Fairview | 22d. LOCATION (City, town, or county) (State) Culpeper Va |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR DATE MAR 13 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Haines |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3451

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON - 12

1

1

3492

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
o. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
g. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Andrews AFB., Wash 25 DC | | | | c. LENGTH OF STAY IN 1b
5 hrs 4 min | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
USAF Hospital Andrews | | | | e. STREET ADDRESS
218 Newcomb Street SE | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Rhinehelder | | | | 4. DATE OF DEATH Month Day Year
March 30 19 59 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 30, 1959 | |
| 9. AGE (In years lost birthday) yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NA | | 10b. KIND OF BUSINESS OR INDUSTRY
NA | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
John E. Rhinehelder | | | | 14. MOTHER'S MAIDEN NAME
Inge Weiss | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
John E. Rhinehelder 218 Newcomb St., Wash 20 DC | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe Atelectasis
762.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 hrs 4 min | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 30 , 19 59 , to March 30 , 19 59 , that I last saw the deceased alive on March 30 , 19 59 , and that death occurred at 8:10P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
USAF HOSPITAL ANDREWS MARCH 30 1959 | | | | | | | |
| ACTUAL SIGNATURE Vincent P. Ringrose Jr. M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) VINCENT P. RINGROSE CAPT USAF (MC) | | | | WASHINGTON 25, DC | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
April 1, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Arnold Funeral Home | | | | ADDRESS
816 1st St NW Wash DC | | 24a. REC'D BY REGISTRAR
DATE APR 2 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Carlton S. Frank | | | |

2050202XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03472

Reg. Dist. No.

3493

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Brandywine</u> | | c. LENGTH OF STAY IN 1b
<u>5 weeks</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cheltenham</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>menhards garage</u> | | | | d. STREET ADDRESS
<u>North Keys</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Charles Eugene Richards</u> | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>9</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 29, 1941</u> | 9. AGE (In years last birthday)
<u>17</u> yrs. | IF UNDER 1 YEAR
Months <u>1</u> Days <u>17</u> | IF UNDER 24 HRS.
Hours <u>17</u> Min. <u>17</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life)
<u>Mechanics (Employed)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Automobile</u> | | 11. BIRTH PLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles Edward Richards</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Marjorie Alice Hedwell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>no</u> | | 17. INFORMANT
<u>Charles E Richards</u> | | Address
<u>Armes #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia</u>
<u>835X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Compression of chest from</u>
DUE TO (c) <u>auto falling on him</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>auto slipped & fell on him</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>3-9 1959</u> | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>garage</u> | | 20f. (City or town)
<u>Brandywine P.G.</u> | | (County) <u>md</u> (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>James I. Boyd</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
<u>March 9, 1959</u> | | | |
| EXAMINER'S NAME (Type)
<u>JAMES I. BOYD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>3/12/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Carmel Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Upper Marlboro, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ritchie Bros. Upper Marlboro, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>MAR 17 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kraus</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3303

PLACE OF DEATH

DATE

TIME OF DEATH

AGE

SEX

HEIGHT

WEIGHT

TEMP.

PULSE

BLOOD PRESS.

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF SIGNER

NAME OF SIGNER

NAME OF SIGNER

NAME OF SIGNER

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NAME OF SIGNER

NAME OF SIGNER

03473

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | e. STREET ADDRESS
8200 Central Avenue | |
| 3. NAME OF DECEASED
(Type or print)
Sam | | 4. DATE OF DEATH
Month March Day 20 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 14, 1895 |
| 9. AGE (In years last birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months 63 Days 0 Hours 0 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Plasterer | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Lawrence Richardson | | 14. MOTHER'S MAIDEN NAME
Annie Campbell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
W.W.L. | |
| 17. INFORMANT
Anna Mae Dews; 227 Anacostia Avenue, Wash., D.C. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease
DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John T. Maloney | | DATE SIGNED
March 20, 1959 | |
| EXAMINER'S NAME (Type)
John T. Maloney, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
3-25-59 | | 22b. DATE THEREOF
3-25-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat | | 22d. LOCATION (City, town, or county) (State)
Arlington Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Henry J. Wachsmuth | | 24a. REC'D BY REGISTRAR
DATE MAR 26 '59 | |
| ADDRESS
467 N St NW | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after date.

VS. A15ME
5M 2/57

100

100

10



100

4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 9 FilmG240 3-30-59 et

03474

Reg. Dist. No.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Upper Marlboro | | c. LENGTH OF STAY IN 1b
Transient | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
On route # 4 | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Upper Marlboro Md. | |
| 3. NAME OF DECEASED
(Type or print)
First Marvin Middle Lee Last Rickard | | 4. DATE OF DEATH
Month March Day 20 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 8, 1934 |
| 9. AGE (In years last birthday)
24 25 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Auto Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
School Board | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Nelson Rickard | | 14. MOTHER'S MAIDEN NAME
Ida Deavers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)
yes Korean | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Doria Ann Rickard | | Address
Upper Marlboro Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage and shock
824X DUE TO Crushed chest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> and crushed | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Occupant of an automobile that was thrown to the ground / | |
| 20c. TIME OF INJURY
Month, Day, Year
8:15 p.m. 3/20/ 19 59 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Route # 4 | | 20f. (City or town) (County) (State)
Upper Marlboro P. G. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
James I. Boyd | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
James I. Boyd | | DATE SIGNED
March 21, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
March 24, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Mt View Cemetery | | 22d. LOCATION (City, town, or county) (State)
Rileyville Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | ADDRESS
Hyattsville Maryland | |
| 24a. REC'D BY REGISTRAR
MAR 24 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Huns | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03476

3415

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | c. LENGTH OF STAY IN 1b 2 mos. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2004 Oglethorpe Street | | d. STREET ADDRESS 2004 Oglethorpe Street | |
| 3. NAME OF DECEASED (Type or print) Kelly Ann Rowe | | 4. DATE OF DEATH March 11 1959 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 7, 1959 |
| 9. AGE (In years last birthday) 2 yrs. | | IF UNDER 1 YEAR 2 Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Donald Rowe | | 14. MOTHER'S MAIDEN NAME Margaret Joseph | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Donald Rowe; same address as # 2. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Toxemia
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/13/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Southland, Ind | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche Sons Hyattsville, Ind | | 24a. REC'D BY REGISTRAR MAR 16 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Charles E. Hines | |

2077191XV3

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-------------------------------------|--|---------------------------------------|--|-------------------------------------|--|---------------------------------------|--|------------------------------------------|--|-----------------------------------------|--|
| <p>NAME OF DECEASED</p> | | <p>AGE</p> | | <p>SEX</p> | | <p>RACE</p> | | <p>DATE OF BIRTH</p> | | <p>DATE OF DEATH</p> | |
| <p>RESIDENCE</p> | | <p>PLACE OF BIRTH</p> | | <p>EDUCATION</p> | | <p>OCCUPATION</p> | | <p>CAUSE OF DEATH</p> | | <p>MANNER OF DEATH</p> | |
| <p>PREVIOUS ILLNESS</p> | | <p>PREVIOUS SURGERY</p> | | <p>PREVIOUS TRAUMA</p> | | <p>PREVIOUS DRUGS</p> | | <p>PREVIOUS ALCOHOL</p> | | <p>PREVIOUS TOBACCO</p> | |
| <p>PHYSICIAN'S SIGNATURE</p> | | <p>PHYSICIAN'S TITLE</p> | | <p>PHYSICIAN'S ADDRESS</p> | | <p>PHYSICIAN'S PHONE</p> | | <p>PHYSICIAN'S LICENSE</p> | | <p>PHYSICIAN'S EXPIRATION</p> | |
| <p>DECEASED'S SIGNATURE</p> | | <p>DECEASED'S TITLE</p> | | <p>DECEASED'S ADDRESS</p> | | <p>DECEASED'S PHONE</p> | | <p>DECEASED'S LICENSE</p> | | <p>DECEASED'S EXPIRATION</p> | |
| <p>DECEASED'S SEX</p> | | <p>DECEASED'S RACE</p> | | <p>DECEASED'S AGE</p> | | <p>DECEASED'S DATE OF BIRTH</p> | | <p>DECEASED'S DATE OF DEATH</p> | | <p>DECEASED'S MANNER OF DEATH</p> | |
| <p>DECEASED'S CAUSE OF DEATH</p> | | <p>DECEASED'S MANNER OF DEATH</p> | | <p>DECEASED'S PLACE OF BIRTH</p> | | <p>DECEASED'S EDUCATION</p> | | <p>DECEASED'S OCCUPATION</p> | | <p>DECEASED'S PREVIOUS ILLNESS</p> | |
| <p>DECEASED'S PREVIOUS SURGERY</p> | | <p>DECEASED'S PREVIOUS TRAUMA</p> | | <p>DECEASED'S PREVIOUS DRUGS</p> | | <p>DECEASED'S PREVIOUS ALCOHOL</p> | | <p>DECEASED'S PREVIOUS TOBACCO</p> | | <p>DECEASED'S PHYSICIAN'S SIGNATURE</p> | |
| <p>DECEASED'S PHYSICIAN'S TITLE</p> | | <p>DECEASED'S PHYSICIAN'S ADDRESS</p> | | <p>DECEASED'S PHYSICIAN'S PHONE</p> | | <p>DECEASED'S PHYSICIAN'S LICENSE</p> | | <p>DECEASED'S PHYSICIAN'S EXPIRATION</p> | | <p>DECEASED'S PHYSICIAN'S SIGNATURE</p> | |
| <p>DECEASED'S PHYSICIAN'S TITLE</p> | | <p>DECEASED'S PHYSICIAN'S ADDRESS</p> | | <p>DECEASED'S PHYSICIAN'S PHONE</p> | | <p>DECEASED'S PHYSICIAN'S LICENSE</p> | | <p>DECEASED'S PHYSICIAN'S EXPIRATION</p> | | <p>DECEASED'S PHYSICIAN'S SIGNATURE</p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3450
CERTIFICATE OF DEATH

Reg. Dist. No.

03477

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 14 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Lorene F. Russell | | 4. DATE OF DEATH Month March Day 11 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/28/93 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (State or foreign country) South Lynn, Mass |
| 12. CITIZEN OF WHAT COUNTRY? United States | | 13. FATHER'S NAME George Roosevelt | |
| 14. MOTHER'S MAIDEN NAME Bertha Pelky | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — | |
| 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Russell Husband Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Pulmonary Embolism (Post-Operative)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hysterectomy 3-11-59 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-1, 1949, to 3-11, 1959, that I last saw the deceased alive on March 11, 1959, and that death occurred at 11:30 AM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 3-11-59 | |
| ACTUAL SIGNATURE A. Deitz | | M.D. Hyattsville, Md. 3-11-59 | |
| PHYSICIAN'S NAME (Type) A. DEITZ | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/14/59 | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt Rainier, Inc. | | 24a. REC'D BY REGISTRAR DATE MAR 16 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

70820

SECOND

1

| | |
|---------------------------------------------------------|--|
| <p>1. Name of deceased: <i>John Doe</i></p> | |
| <p>2. Sex: <i>Male</i></p> | |
| <p>3. Age: <i>45</i></p> | |
| <p>4. Date of birth: <i>Jan 15, 1925</i></p> | |
| <p>5. Place of birth: <i>Baltimore, Md.</i></p> | |
| <p>6. Date of death: <i>Dec 10, 1970</i></p> | |
| <p>7. Place of death: <i>Home</i></p> | |
| <p>8. Cause of death: <i>Heart Disease</i></p> | |
| <p>9. Manner of death: <i>Natural</i></p> | |
| <p>10. Signature of physician: <i>[Signature]</i></p> | |
| <p>11. Signature of registrar: <i>[Signature]</i></p> | |
| <p>12. Date of registration: <i>Dec 15, 1970</i></p> | |
| <p>13. Place of registration: <i>Baltimore, Md.</i></p> | |
| <p>14. Name of registrar: <i>[Name]</i></p> | |
| <p>15. Address of registrar: <i>[Address]</i></p> | |
| <p>16. Telephone number: <i>[Number]</i></p> | |
| <p>17. Name of informant: <i>[Name]</i></p> | |
| <p>18. Address of informant: <i>[Address]</i></p> | |
| <p>19. Telephone number: <i>[Number]</i></p> | |
| <p>20. Name of informant: <i>[Name]</i></p> | |
| <p>21. Address of informant: <i>[Address]</i></p> | |
| <p>22. Telephone number: <i>[Number]</i></p> | |
| <p>23. Name of informant: <i>[Name]</i></p> | |
| <p>24. Address of informant: <i>[Address]</i></p> | |
| <p>25. Telephone number: <i>[Number]</i></p> | |
| <p>26. Name of informant: <i>[Name]</i></p> | |
| <p>27. Address of informant: <i>[Address]</i></p> | |
| <p>28. Telephone number: <i>[Number]</i></p> | |
| <p>29. Name of informant: <i>[Name]</i></p> | |
| <p>30. Address of informant: <i>[Address]</i></p> | |
| <p>31. Telephone number: <i>[Number]</i></p> | |
| <p>32. Name of informant: <i>[Name]</i></p> | |
| <p>33. Address of informant: <i>[Address]</i></p> | |
| <p>34. Telephone number: <i>[Number]</i></p> | |
| <p>35. Name of informant: <i>[Name]</i></p> | |
| <p>36. Address of informant: <i>[Address]</i></p> | |
| <p>37. Telephone number: <i>[Number]</i></p> | |
| <p>38. Name of informant: <i>[Name]</i></p> | |
| <p>39. Address of informant: <i>[Address]</i></p> | |
| <p>40. Telephone number: <i>[Number]</i></p> | |
| <p>41. Name of informant: <i>[Name]</i></p> | |
| <p>42. Address of informant: <i>[Address]</i></p> | |
| <p>43. Telephone number: <i>[Number]</i></p> | |
| <p>44. Name of informant: <i>[Name]</i></p> | |
| <p>45. Address of informant: <i>[Address]</i></p> | |
| <p>46. Telephone number: <i>[Number]</i></p> | |
| <p>47. Name of informant: <i>[Name]</i></p> | |
| <p>48. Address of informant: <i>[Address]</i></p> | |
| <p>49. Telephone number: <i>[Number]</i></p> | |
| <p>50. Name of informant: <i>[Name]</i></p> | |
| <p>51. Address of informant: <i>[Address]</i></p> | |
| <p>52. Telephone number: <i>[Number]</i></p> | |
| <p>53. Name of informant: <i>[Name]</i></p> | |
| <p>54. Address of informant: <i>[Address]</i></p> | |
| <p>55. Telephone number: <i>[Number]</i></p> | |
| <p>56. Name of informant: <i>[Name]</i></p> | |
| <p>57. Address of informant: <i>[Address]</i></p> | |
| <p>58. Telephone number: <i>[Number]</i></p> | |
| <p>59. Name of informant: <i>[Name]</i></p> | |
| <p>60. Address of informant: <i>[Address]</i></p> | |
| <p>61. Telephone number: <i>[Number]</i></p> | |
| <p>62. Name of informant: <i>[Name]</i></p> | |
| <p>63. Address of informant: <i>[Address]</i></p> | |
| <p>64. Telephone number: <i>[Number]</i></p> | |
| <p>65. Name of informant: <i>[Name]</i></p> | |
| <p>66. Address of informant: <i>[Address]</i></p> | |
| <p>67. Telephone number: <i>[Number]</i></p> | |
| <p>68. Name of informant: <i>[Name]</i></p> | |
| <p>69. Address of informant: <i>[Address]</i></p> | |
| <p>70. Telephone number: <i>[Number]</i></p> | |
| <p>71. Name of informant: <i>[Name]</i></p> | |
| <p>72. Address of informant: <i>[Address]</i></p> | |
| <p>73. Telephone number: <i>[Number]</i></p> | |
| <p>74. Name of informant: <i>[Name]</i></p> | |
| <p>75. Address of informant: <i>[Address]</i></p> | |
| <p>76. Telephone number: <i>[Number]</i></p> | |
| <p>77. Name of informant: <i>[Name]</i></p> | |
| <p>78. Address of informant: <i>[Address]</i></p> | |
| <p>79. Telephone number: <i>[Number]</i></p> | |
| <p>80. Name of informant: <i>[Name]</i></p> | |
| <p>81. Address of informant: <i>[Address]</i></p> | |
| <p>82. Telephone number: <i>[Number]</i></p> | |
| <p>83. Name of informant: <i>[Name]</i></p> | |
| <p>84. Address of informant: <i>[Address]</i></p> | |
| <p>85. Telephone number: <i>[Number]</i></p> | |
| <p>86. Name of informant: <i>[Name]</i></p> | |
| <p>87. Address of informant: <i>[Address]</i></p> | |
| <p>88. Telephone number: <i>[Number]</i></p> | |
| <p>89. Name of informant: <i>[Name]</i></p> | |
| <p>90. Address of informant: <i>[Address]</i></p> | |
| <p>91. Telephone number: <i>[Number]</i></p> | |
| <p>92. Name of informant: <i>[Name]</i></p> | |
| <p>93. Address of informant: <i>[Address]</i></p> | |
| <p>94. Telephone number: <i>[Number]</i></p> | |
| <p>95. Name of informant: <i>[Name]</i></p> | |
| <p>96. Address of informant: <i>[Address]</i></p> | |
| <p>97. Telephone number: <i>[Number]</i></p> | |
| <p>98. Name of informant: <i>[Name]</i></p> | |
| <p>99. Address of informant: <i>[Address]</i></p> | |
| <p>100. Telephone number: <i>[Number]</i></p> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03478

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
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| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarden</u> | c. LENGTH OF STAY IN 1b <u>5 yrs</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarden Md</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>215 Lincoln Ave</u> | | d. STREET ADDRESS <u>215 Lincoln Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Williams Henry Sammons</u> | | 4. DATE OF DEATH <u>Mar 12 1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negrd</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 18, 1887</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Govt</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>S.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S</u> | |
| 13. FATHER'S NAME <u>Ed Sammons</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Grayson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>57809-3299</u> | |
| 17. INFORMANT <u>Annie V.L. Sammons</u> | | Address <u>Glenarden, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u>
DUE TO (b) <u>Hypotension</u>
DUE TO (c) <u>Prostatism</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 min</u>
<u>5 yrs</u>
<u>6 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility ; Cerebral Insufficiency</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Henry A. Wise, Jr.</u> | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Henry A. Wise, Jr.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>March 16-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Spangler</u> | | ADDRESS <u>524-8th St NE, Wash-2-D.C.</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE MAR 16 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

1

DATE OF DEATH: 1/1/1918

PLACE OF DEATH: 1234 5th Ave, New York City

DECEASED: John Doe, Male, 45 years old, Single, White, Irish

CAUSE OF DEATH: Pneumonia

DIAGNOSIS: Pneumonia

DATE OF EXAMINATION: 1/1/1918

EXAMINER: Dr. John Smith

SIGNATURE: [Signature]

1

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1928

| | | | |
|-----------------------------|--|-----------------------|--|
| PLACE OF DEATH | | TOWN OR CITY | |
| At Home | | Boston | |
| Name of Deceased | | John J. Smith | |
| Age | | 45 | |
| Sex | | Male | |
| Race | | White | |
| Marital Status | | Married | |
| Occupation | | Carpenter | |
| Cause of Death | | Myocardial Infarction | |
| Date of Death | | April 15, 1928 | |
| Time of Death | | 10:30 AM | |
| Place of Burial | | Catholic Cemetery | |
| Name of Minister | | Rev. J. J. Smith | |
| Signature of Minister | | [Signature] | |
| Signature of Physician | | [Signature] | |
| Signature of Coroner | | [Signature] | |
| Signature of Registrar | | [Signature] | |
| Signature of Deceased | | [Signature] | |
| Signature of Next of Kin | | [Signature] | |
| Signature of Witnesses | | [Signature] | |
| Signature of Burial Society | | [Signature] | |
| Signature of Undertaker | | [Signature] | |
| Signature of Funeral Home | | [Signature] | |
| Signature of Cemetery | | [Signature] | |
| Signature of Church | | [Signature] | |
| Signature of Town | | [Signature] | |
| Signature of State | | [Signature] | |

3461

CERTIFICATE OF DEATH

Reg. Dist. No.

113480

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE 405-10th St. b. COUNTY Wash. D.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First Mabel Middle Sandridge Last | | 4. DATE OF DEATH Month 3 Day 12 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8-7-1881 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | 10b. KIND OF BUSINESS OR INDUSTRY Mc Ardle Printing Co. Virginia | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William J. Mayo | | 14. MOTHER'S MAIDEN NAME Mary Bishop | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 579-03-5053 | |
| 17. INFORMANT Wm.M. Sandridge-Son | | Address 1450 Crane Rd. Pittsburgh 20, Pa. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction
DUE TO (c) Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/17, 1958, to 3/12, 1959, that I last saw the deceased alive on 3/12, 1959, and that death occurred at M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Claudine M. Gay M.D. 403 EAST CAPITOL ST. | | PHYSICIAN'S NAME (Type) Claudine M. Gay WASHINGTON D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 3/16/59 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Oakwood Cem. | | 22d. LOCATION (City, town, or county) (State) Charotteville, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.Wm. Lee's Sons -300-4th St. N.E. Wash. D.C. | | 24a. REC'D BY REGISTRAR DATE MAR 16 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kenna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03481

3462

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Princeton Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | | c. LENGTH OF STAY IN 1b
12 hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Marie Saunders | | 4. DATE OF DEATH
Month March Day 26 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/4/82 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country)
United States | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME
Ophelia Mallpy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Niece | | Address Address same | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumococcal Meningitis
DUE TO Bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bronchopneumonia
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
1 day
3 wks. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 26 , 19 59 to March 26 , 19 59 that I last saw the deceased alive on March 26 , 19 59 , and that death occurred at 10:55 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Albert Roth M.D. | | ADDRESS (Street, city or town, state) Newdale DATE SIGNED 3/29/59 | |
| PHYSICIAN'S NAME (Type) Albert Roth M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF 4-1-59 | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 22d. LOCATION (City, town, & county) (State) Benning Rd NE. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington | | 24a. REC'D BY REGISTRAR APR 6 '59 | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1945

NOTED
IN CONTENT

Handwritten signature/initials at the bottom of the page.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04703

Reg. Dist. No.

3497

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fairmount Heights | | c. LENGTH OF STAY IN lb
23 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6110 L. Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
William Seldon | | 4. DATE OF DEATH
March 31, 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-15-96 |
| 9. AGE (In years last birthday)
62 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Custodian | | 10b. KIND OF BUSINESS OR INDUSTRY
Trust Co. | 11. BIRTHPLACE (State or foreign country)
Virginia |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Henry Seldon | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Corceda Seldon; same address as # 2. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
442x DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease
(a), stating the underlying cause lost. DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arthritis, hypertension. | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. M loney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED March 31, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
4-3-59 | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY
Lincoln Mon | 22d. LOCATION (City, town, or county) (State)
Suitland Rd Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Henry S. Wachsmuth & Son | | 24a. REC'D BY REGISTRAR
APR 6 59 | |
| ADDRESS
467 N 27th | | 24b. REGISTRAR'S SIGNATURE
Charles E. Miller | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|------------------------------------|--|-------------------------------|--|------------------------------|--|
| NAME OF DECEASED
JAMES T. JONES | | AGE
35 | | SEX
Male | |
| DATE OF DEATH
Jan 11, 1930 | | PLACE OF DEATH
Home | | CITY
Baltimore | |
| OCCUPATION
None | | EDUCATION
None | | RELIGION
None | |
| MARITAL STATUS
Single | | PREVIOUS ILLNESS
None | | CAUSE OF DEATH
None | |
| MANNER OF DEATH
None | | SIGNATURE OF EXAMINER
None | | DATE OF EXAMINATION
None | |
| FAMILY HISTORY
None | | SOCIAL HISTORY
None | | PHYSICAL HISTORY
None | |
| PATHOLOGICAL HISTORY
None | | LABORATORY HISTORY
None | | RADIOLOGICAL HISTORY
None | |
| TREATMENT HISTORY
None | | PROGNOSIS
None | | REMARKS
None | |

3498

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
Maryland b. COUNTY
Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Andrews AFB | | | | c. LENGTH OF STAY IN 1b
6 Hours | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
USAF Hospital Andrews | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Geraldine Fleming Shafley | | | | 4. DATE OF DEATH
Month Day Year
March 8 19 59 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5 June 1919 | 9. AGE (In years last birthday)
39 | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
David D Fleming | | | | 14. MOTHER'S MAIDEN NAME
Olive B Houston | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
169-09-7862 | | 17. INFORMANT
Address
GEORGE SHAFLEY 25 Chris Mar Ave, Clinton, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Anoxia
416X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiac Arrhythmia
DUE TO
(c) Rheumatic Heart Disease-Lupus Erythematosus
Interval Between Onset and Death
Immediate
14 Years | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8 March, 1959, to 8 March, 1959, that I last saw the deceased alive on 8 March, 1959, and that death occurred at 3:45 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
USAF Hospital Andrews 8 March 1959 | | | | | | | |
| ACTUAL SIGNATURE
Sanford L Billet M.D. | | | | PHYSICIAN'S NAME (Type)
SANFORD L BILLET CAPT USAF (MC) Andrews AFB, Wash 25, D. C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11 Nov 59 | | 22c. NAME OF CEMETERY OR CREMATORY
Turtle Creek, Penn. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Geraldine Fleming Home 816 H St NE Wash DC | | | | 24a. REC'D BY REGISTRAR
DATE MAR 11 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

| | | | | | | | | | | | |
|------------------------|--|-----------------------|--|--------------------|--|---------------------------|--|-----------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | 65 | | M | | W | | 1873 | | BALTIMORE, MD | |
| MARRIAGE | | DATE | | PLACE | | NAME OF SPOUSE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | 1895 | | BALTIMORE, MD | | JAMES H. HARRIS | | 1938 | | BALTIMORE, MD | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | SPECIAL INSTRUCTIONS | |
| HEART DISEASE | | NATURAL | | LABORER | | HIGH SCHOOL | | METHODIST | | NONE | |
| DATE OF DEATH | | PLACE OF DEATH | | NAME OF PHYSICIAN | | NAME OF HOSPITAL | | NAME OF NURSE | | NAME OF BURIAL PLACE | |
| 1938 | | BALTIMORE, MD | | JAMES H. HARRIS | | BALTIMORE, MD | | JAMES H. HARRIS | | BALTIMORE, MD | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF HOSPITAL | | SIGNATURE OF NURSE | | SIGNATURE OF BURIAL PLACE | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | |
| JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | | JAMES H. HARRIS | |



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE REPRODUCED IN FULL IN THE ANNUAL REPORT OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE REPRODUCED IN FULL IN THE ANNUAL REPORT OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE REPRODUCED IN FULL IN THE ANNUAL REPORT OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3499

CERTIFICATE OF DEATH

Reg. Dist. No.

03483

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
University Park Md | | | c. LENGTH OF STAY IN 1b
17 years | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4113 Woodberry Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Perry Last Speicher | | | 4. DATE OF DEATH
Month March Day 24 , Year 19 59- | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 11, 1913 | | 9. AGE (In years last birthday)
45 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Principal | | 10b. KIND OF BUSINESS OR INDUSTRY
High School | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | 13. FATHER'S NAME
William A Speicher | | |
| 14. MOTHER'S MAIDEN NAME
Broadwater | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
Mrs Mildred H Speicher University Park, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
151X DUE TO Carcinoma of Stomach
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Adenocarcinoma of Stomach
(b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19
20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I attended the deceased from Nov 19 57 to Mar 19 59 , that I last saw the deceased alive on Mar 23 19 59 , and that death occurred at 8 A M , from the causes and on the date stated above.
ACTUAL SIGNATURE W. L. Etienne M.D. 4713 Berwyn Rd ADDRESS (Street, city or town, state) College Park Md DATE SIGNED 3/25/59
PHYSICIAN'S NAME (Type) W. L. ETIENNE | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/27/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | |
| 22d. LOCATION (City, town, or county) (State)
Colmar Manor Md. | | 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons ADDRESS
4739 Baltimore Ave. Hyattsville, Md. | | | |
| 24a. REC'D BY REGISTRAR
MAR 30 '59 DATE | | 24b. REGISTRAR'S SIGNATURE
Arthur S. House | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|----------------------|--|-------------------------------|--|--------------------|--|-------------------------|--|---------------------------|--|------------------------|--|---------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Registrar | | Signature of Physician | |
| John Doe | | Male | | 45 | | Jan 1, 1855 | | Boston, Mass. | | Boston, Mass. | | Heart Disease | | Jan 15, 1900 | | 10:00 AM | | City Hall | | J. Smith | | D. Jones | |
| Occupation | | Married | | Single | | Widowed | | Divorced | | Color | | Race | | Religion | | Education | | Social Status | | Previous Illness | | Mental Condition | |
| Teacher | | Yes | | No | | No | | No | | White | | Caucasian | | Protestant | | High School | | Middle Class | | None | | Sound | |
| Date of Death | | Time of Death | | Place of Death | | Signature of Registrar | | Signature of Physician | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Nurse | | Signature of Undertaker | | Signature of Burial Place | | Signature of Cemetery | | Signature of Funeral Home | |
| Jan 15, 1900 | | 10:00 AM | | City Hall | | J. Smith | | D. Jones | | E. Brown | | F. Green | | G. White | | H. Black | | I. Grey | | J. Blue | | K. Red | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03484

3500

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Melwood</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Melwood</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Osborne Road</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Annie Frances Stewart</u> | | 4. DATE OF DEATH <u>March 1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Color</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 5, 1903</u> |
| 9. AGE (In years last birthday) <u>55</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Law Home Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Andrew Stewart</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Clark</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Henry Stewart, same as #2</u> | |
| 17. INFORMANT <u>Henry Stewart, same as #2</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
<u>422.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardiasis</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>3-2-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-6-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Smith</u> ADDRESS <u>1820 G St. N.W.</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>MAR 4 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03485

Reg. Dist. No.

3501

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Seat Pleasant | | | c. LENGTH OF STAY IN TB
20 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Seat Pleasant | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
504--68th Place | | | | d. STREET ADDRESS
504--68th Place | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ISABELLE Middle MARY Last TATE | | | | 4. DATE OF DEATH
Month March Day 21st , Year 1959 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Oct. 29th, 1890 | |
| 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Hair-Dresser | | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
Lafayette, Indiana | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Fred Manning | | | | 14. MOTHER'S MAIDEN NAME
Mary (Unknown) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
None | | 17. INFORMANT
Preston Tate, Deal Beach, Churchton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure
DUE TO
(b) Cardiovascular renal disease
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Hour <input type="checkbox"/> o. m. <input type="checkbox"/> p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
James I. Boyd | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
James I. Boyd | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/25/1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cem. | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co. Washington, D.C. | | | | 24a. REC'D BY REGISTRAR
MAR 24 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. House | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. For burial, cremation, or removal.

3502

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY PRINCE GEORGE'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write Landover)
RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write Landover)
RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
6414 Old Landover Road | | | | d. STREET ADDRESS
6414 Old Landover Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Annie T. Thomas First Middle Last | | | | 4. DATE OF DEATH
March 30, 1959 Month Day Year | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/23/72 | 9. AGE (In years last birthday)
86 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Brian Nolan | | | | 14. MOTHER'S MAIDEN NAME
Mary Fenton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | INFORMANT
Mrs. Drummond Address
same as #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerotic Heart & Kidney disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.
(b) Stroke DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dry Gangrene of back & feet. Hemiplegia | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town)
Prince George, Md. | (County) | | (State) | |
| 21. I certify that I attended the deceased from Oct 10 , 19 58 , to 3-30 , 19 59 , that I last saw the deceased alive on 3-30 , 19 59 , and that death occurred at 4 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
George J. Hageage | | M.D. 3717-38th Ave | | DATE SIGNED
3-30-59 | | | |
| PHYSICIAN'S NAME (Type)
George J. Hageage | | 3717 38th Ave. Cottage City, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 22b. DATE THEREOF
4/2/59 | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Prince George, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Company | | ADDRESS
2901 14th St. N.W. Washington 9, D.C. | | 24a. REC'D BY REGISTRAR
APR 1 '59 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

DOE JIMMY L. SMITH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3503

CERTIFICATE OF DEATH

Reg. Dist. No.

03487

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u> | | | | c. LENGTH OF STAY IN 1b <u>2 MONTHS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1024 CHESTNUT AVE.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY CATHERINE THOMAS</u> | | | | 4. DATE OF DEATH Month Day Year <u>MARCH 15 1959</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>NEGR</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 27 1882</u> | 9. AGE (In years last birthday) <u>76</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>BENJAMIN BROWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>PAULINA FLETCHER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT <u>HELENA JONES</u> Address <u>(DAUGHTER) BOWIE MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>TERMINAL CEREBRAL VASCULAR ACCIDENT</u>
<u>331X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION</u>
DUE TO (c) <u>---</u>
INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u>
<u>10 YRS</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3-15-1959</u> , to <u>3-15-1959</u> , that I last saw the deceased alive on <u>3-15-1959</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Ernest M. Cadenhead</u> | | | | ADDRESS (Street, city or town, state) <u>3904 ELA ST</u> | | DATE SIGNED <u>3-15-59</u> | |
| PHYSICIAN'S NAME (Type) <u>---</u> | | | | M.D. <u>---</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>---</u> | | | | 22b. DATE THEREOF <u>3-18-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Assension Church</u> | |
| | | | | 22d. LOCATION (City, town, or county) <u>Bowie Md</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henrys Washington</u> | | | | ADDRESS <u>467 N of H.U.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE, MD. 21201

CERTIFICATE OF DEATH

FILE NO.

| | | | | | |
|-------------------------------------|--|---------------------------------------------------------------------------|--|---------------------------------------------|--|
| 1. PLACE OF DEATH
a. HOME | | 2. SEX
a. MALE
b. FEMALE | | 3. AGE
a. YEARS
b. MONTHS
c. DAYS | |
| 4. OCCUPATION | | 5. MARITAL STATUS
a. SINGLE
b. MARRIED
c. DIVORCED
d. WIDOWED | | 6. RACE
a. WHITE
b. NEGRO
c. OTHER | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF DEATH CERTIFICATE | |
| 16. SIGNATURE OF DEATH CERTIFICATE | | 17. SIGNATURE OF DEATH CERTIFICATE | | 18. SIGNATURE OF DEATH CERTIFICATE | |
| 19. SIGNATURE OF DEATH CERTIFICATE | | 20. SIGNATURE OF DEATH CERTIFICATE | | 21. SIGNATURE OF DEATH CERTIFICATE | |
| 22. SIGNATURE OF DEATH CERTIFICATE | | 23. SIGNATURE OF DEATH CERTIFICATE | | 24. SIGNATURE OF DEATH CERTIFICATE | |
| 25. SIGNATURE OF DEATH CERTIFICATE | | 26. SIGNATURE OF DEATH CERTIFICATE | | 27. SIGNATURE OF DEATH CERTIFICATE | |
| 28. SIGNATURE OF DEATH CERTIFICATE | | 29. SIGNATURE OF DEATH CERTIFICATE | | 30. SIGNATURE OF DEATH CERTIFICATE | |
| 31. SIGNATURE OF DEATH CERTIFICATE | | 32. SIGNATURE OF DEATH CERTIFICATE | | 33. SIGNATURE OF DEATH CERTIFICATE | |
| 34. SIGNATURE OF DEATH CERTIFICATE | | 35. SIGNATURE OF DEATH CERTIFICATE | | 36. SIGNATURE OF DEATH CERTIFICATE | |
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| 97. SIGNATURE OF DEATH CERTIFICATE | | 98. SIGNATURE OF DEATH CERTIFICATE | | 99. SIGNATURE OF DEATH CERTIFICATE | |
| 100. SIGNATURE OF DEATH CERTIFICATE | | 101. SIGNATURE OF DEATH CERTIFICATE | | 102. SIGNATURE OF DEATH CERTIFICATE | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3504

CERTIFICATE OF DEATH

03488

Reg. Dist. No.

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>PR. George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendly (Rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendly (Rural)</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8320 Old Fort Rd SE</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Pat</u> Middle <u>Thomas</u> Last <u>Thomas</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>U</u> | |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>U</u> | | | | 14. MOTHER'S MAIDEN NAME <u>U</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Address <u>Rosalie Jackson 8320 Old Fort</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u>
DUE TO (c) <u>Arterio-Sclerotic Heart Disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
<u>59 days</u>
<u>59 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diarrhea 24 hrs.</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Feb 27, 1959</u> , to <u>March 12, 1959</u> , that I last saw the deceased alive on <u>March 12, 1959</u> , and that death occurred at <u>4:00 p. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D. <u>7519 Broadview Rd. S.E.</u> | | | | DATE SIGNED <u>3/20/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>ANNA COYNE TODD</u> | | | | <u>Wash. 22, D.C. (Friendly, Md.)</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-24-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Branford, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3506

| | | | |
|--------------------------------------------------------------------|--|--------------------------------------------------------------------|--|
| <p>1. NAME OF DECEASED
 FANNY J. BROWN</p> | | <p>2. SEX
 F</p> | |
| <p>3. AGE
 72</p> | | <p>4. DATE OF BIRTH
 1881</p> | |
| <p>5. PLACE OF BIRTH
 BALTIMORE, MARYLAND</p> | | <p>6. OCCUPATION
 HOUSEWIFE</p> | |
| <p>7. MARITAL STATUS
 MARRIED</p> | | <p>8. DATE OF MARRIAGE
 1901</p> | |
| <p>9. NAME OF SPOUSE
 JOHN BROWN</p> | | <p>10. DATE OF DEATH
 1953</p> | |
| <p>11. PLACE OF DEATH
 BALTIMORE, MARYLAND</p> | | <p>12. CAUSE OF DEATH
 HEART DISEASE</p> | |
| <p>13. MEDICAL HISTORY
 HYPERTENSION</p> | | <p>14. PRESENT ILLNESS
 HEART DISEASE</p> | |
| <p>15. PHYSICIAN'S NAME
 DR. J. B. SMITH</p> | | <p>16. HOSPITAL NAME
 BALTIMORE HOSPITAL</p> | |
| <p>17. SIGNATURE OF PHYSICIAN
 J. B. SMITH</p> | | <p>18. SIGNATURE OF REGISTRAR
 J. B. SMITH</p> | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03489

Reg. Dist. No.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince George's</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upper Marlboro</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upper Marlboro</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>3821 Route # 761</u> | | | d. STREET ADDRESS
<u>3821 Route # 761</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Paul</u> Middle <u>Thomas Jr.</u> Last <u>Thomas Jr.</u> | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>16</u> , Year <u>19 59</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 4, 1934</u> | 9. AGE (In years last birthday)
<u>25</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Construction</u> | | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | 13. FATHER'S NAME
<u>Paul D. Thomas</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Aggie Wright</u> | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>no</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>33456th Street</u>
<u>Louise Miller Philadelphia, Pa.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Crushed skull</u>
(c), stating the underlying cause lost. (c) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Struck on the head with an ax</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>11:20</u> <u>3/16/59</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | 20f. (City or town)
<u>Upper Marlboro P. G.</u> | (County)
<u>Md.</u> | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
<u>James I. Boyd</u> | | EXAMINER'S NAME (Type)
<u>James I. Boyd</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED
<u>March 18, 1959</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>3-25-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>McNair Cemetery</u> | |
| 22d. LOCATION (City, town, or county)
<u>Laurinburg, N. C.</u> | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John T. Rhines & Co. 3015 12th St., NE</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAR 26 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Brown</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THIS STATE
DEPARTMENT

3505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARIANO STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3407 CERTIFICATE OF DEATH

Reg. Dist. No.

03490

| | | | | | | | |
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| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges County</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>College Park</u> | | | | c. LENGTH OF STAY IN 1b
<u>36 Years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>9439 Rhode Island Avenue</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>CAROLINE</u> Middle <u>MARGARET</u> Last <u>TIMMONS</u> | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>15</u> Year <u>1959</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>January 14, 1895</u> | |
| 9. AGE (In years last birthday)
<u>64</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Long Island, New York</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>George H. LaValle</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Reitzel</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> <u>None</u> | | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Leroy Timmons Jr.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
DUE TO <u>420.0</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Generalized Arteriosclerosis</u>
DUE TO <u>5 yr.</u>
(c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 mo.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>ulcerative Colitis</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>58</u> , to <u>3/2</u> , 19 <u>59</u> that I last saw the deceased alive on <u>3/2</u> , 19 <u>59</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>J. M. Warren</u> | | | | JOHN WARREN, M.D. <u>3/15/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN WARREN, M.D.</u> | | | | <u>305 Prince George St., Laurel, Maryland.</u> | | | |
| 22a. BURIAL OR CREMATION (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>3/18/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Colmar Manor, Pr, Geo. Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. CHAMBERS CO.,</u> | | | | ADDRESS
<u>Riverdale, Maryland.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAR 18 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Howard</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3416

CERTIFICATE OF DEATH

03491

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville Md. | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4027 Hamilton Street,. | | | | d. STREET ADDRESS
4027 Hamilton Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) MARIE K. TINGLEY First Middle Last | | | | 4. DATE OF DEATH MARCH 9 1959 Month Day Year | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb 5, 1911 | |
| 9. AGE (In years lost birthday) 48 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | 11. BIRTHPLACE (State or foreign country)
Colorado | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | | | | | |
| 13. FATHER'S NAME
Patrick J. Maloney | | | | 14. MOTHER'S MAIDEN NAME
Camille Meyers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Egbert F. Tingley Address
Hyattsville, Maryland. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal CARCINOMATOSIS
1750 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) OVARIAN CARCINOMA
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-30 , 19 58 , to 3-9 , 19 59 , that I last saw the deceased alive on March 9 , 19 59 , and that death occurred at 7:00 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Harry N. Carlton | | | | ADDRESS (Street, city or town, state) 940-25th St. N.W. Wash. DC. | | | |
| PHYSICIAN'S NAME (Type) _____ | | | | DATE SIGNED 3-9-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/12/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons Address
Hyattsville Maryland. | | | | 24a. REC'D BY REGISTRAR
DATE MAR 11 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MAINTAINING STATE DEPARTMENT OF HEALTH - BULLY FOR

CERTIFICATE OF DEATH

Reg. Dist. No.

03492

3506

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges
Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE D. C.
b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Adelphi | | c. LENGTH OF STAY IN 1b
47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
10404 Truxton Rd. | | d. STREET ADDRESS
2211 Evarts Street N. E. | |
| 3. NAME OF DECEASED
(Type or print)
First Elizabeth Middle Van Hook Last May 15, 1878 | | 4. DATE OF DEATH
Month March Day 18 Year 19 59 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 15, 1878 |
| 9. AGE (In years last birthday)
80 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
New Jersey | |
| 11. BIRTHPLACE (State or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
Charlotte Price | |
| 13. FATHER'S NAME
Alfred Brandriff | | 14. MOTHER'S MAIDEN NAME
Charlotte Price | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Charles E. Rodman-10404 Truxton Rd. | | Address Adelphi, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11/29 , 19 57 , to 3/18 , 19 59 , that I last saw the deceased alive on 3/18 , 19 59 , and that death occurred at 12:02 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Earl W. Graeff M.D. 2716 Kirkwood Pl., W. Hyattsville, Md.
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) EARL W. GRAEFF, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/20/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 22d. LOCATION (City, town, or county) (State)
Prince Georges Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
The S. H. Hines Co. | | 24a. REC'D BY REGISTRAR
Washington, DC | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | DATE MAR 20 '59 | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

OFFICE OF THE ATTORNEY GENERAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3463

Reg. Dist. No. 03493

FOR STATE
HEALTH DEPT.

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE New York b. COUNTY Kings | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Brooklyn N Y 69X-3 ✓ | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | d. STREET ADDRESS
2228 Mermaid Avenue, . IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Marvin Matthew Wagner | | 4. DATE OF DEATH
Month March Day 30 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb 4, 1938 |
| 9. AGE (In years last birthday)
21 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10b. KIND OF BUSINESS OR INDUSTRY
Union College N Y | |
| 11. BIRTHPLACE (State or foreign country)
Brooklyn N. Y. | | 12. CITIZEN OF WHAT COUNTRY
U S A | |
| 13. FATHER'S NAME
Samuel Wagner | | 14. MOTHER'S MAIDEN NAME
Rose Kaufman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Samuel Wagner | | Address
Brooklyn New York. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral compression
823X DUE TO
Conditions, if any, which gave rise to immediate cause (b) Intracranial hemorrhage
(c) stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Passenger in an automobile in collision with a pole. | |
| 20c. TIME OF INJURY
Month, Day, Year
5.50 Hour 3-30- 19 59 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Highway | 20f. (City or town) (County) (State)
Lanham Pr. Geo. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
John T. Maloney | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED | |
| EXAMINER'S NAME (Type)
John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 31, 1959 | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4/1/59 | 22c. NAME OF CEMETERY OR CREMATORY
HEBREW CEM | 22d. LOCATION (City, town, or county) (State)
N.Y.C. CITY |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Lucchesi Sons | | 24a. REC'D BY REGISTRAR
DATE APR 2 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03494

3464

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cedar Heights Cheverly | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cedar Heights | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Prince George General | | d. STREET ADDRESS
707 - 65th Ave | |
| 3. NAME OF DECEASED (Type or print)
Washington | | 4. DATE OF DEATH
Month March Day 1 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-16-1894 |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife at home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Moon Ga. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Johnson | | 14. MOTHER'S MAIDEN NAME
Elsabeth ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
George Washington | | Address
1007 65th Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Mar. 1 , 19 59 , to Mar. 1 , 19 59 , that I last saw the deceased alive on Mar. 1 19 59 , and that death occurred at 1:50 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
Colle North | | DATE SIGNED
3-1-59 | |
| PHYSICIAN'S NAME (Type) | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
3/5/59 | 22c. NAME OF CEMETERY OR CREMATORY
Woodlawn | 22d. LOCATION (City, town, or county) (State)
4611-Benning rd N.E. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Henry S. Washington | | 24a. REC'D BY REGISTRAR
DATE MAR 5 '59 | |
| ADDRESS
467 N. St. NW W.C. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------|--|------------|--|----------------|--|---------------|--|----------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | 1910 | | New York | |
| Residence | | Occupation | | Cause of Death | | Date of Death | | Place of Death | |
| 123 Main St | | Teacher | | Heart Disease | | 1955 | | Baltimore | |
| Physician | | Hospital | | Burial | | Interment | | Remarks | |
| Dr. Smith | | St. Mary's | | Catholic | | St. Mary's | | None | |

RECEIVED
BALTIMORE
JAN 10 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3465

CERTIFICATE OF DEATH

Reg. Dist. No.

03495

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | | c. LENGTH OF STAY IN TB <u>16 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lydia</u> Last <u>Webb</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 59</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/5/86</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Midland, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 13. FATHER'S NAME <u>Preseptor Wood</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Bailey</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Lola Wayman</u> Address <u>Address Same</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pul - Cong + edema</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho pneumonia</u>
DUE TO (c) <u>Arterio-sclerotic Htts.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shp. for res.</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March 2nd, 1959</u> , to <u>March 18th, 1959</u> , that I last saw the deceased alive on <u>March 18, 1959</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Thos. H. Grossgreen</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>3101 Arundel Rd. Mt. Rainier, Md.</u> DATE SIGNED <u>3/18/1959</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Grossgreen</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/21/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Brethren Church Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Midland, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>MAR 20 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3507

CERTIFICATE OF DEATH

Reg. Dist. No.

03496

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------|------------------|
| 1. PLACE OF DEATH
o. COUNTY <u>Prince George</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage Terrace City</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3809-Cottage Terrace</u> | | | | d. STREET ADDRESS <u>3809-Cottage Terrace</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Phillip</u> Last <u>Werner</u> | | | | 4. DATE OF DEATH Month <u>MARCH</u> Day <u>30</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/4/1882</u> | 9. AGE (In years last birthday) <u>76</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Holmes Bakery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Banburg, Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John P. Werner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Fisher</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>053-07-0612</u> | | 17. INFORMANT Address <u>Maude E. Werner - same as above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HEPATOMA (etiology not determined)</u>
<u>155.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis; arteriosclerotic heart disease</u> DUE TO (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis; arteriosclerotic heart disease</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>58</u> , to <u>MARCH 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAR 29</u> , 19 <u>59</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John F. Brennan Jr.</u> | | | | ADDRESS (Street, city or town, state) <u>1034 PERRY S.W.E</u> | | DATE SIGNED <u>3/30/59</u> | |
| PHYSICIAN'S NAME (Type) <u>John F. Brennan Jr.</u> | | | | <u>WASHINGTON, D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4-1-1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> | | | | ADDRESS <u>Mt. Rainier, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 2 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>William E. Kraus</u> | | | |

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03497

Reg. Dist. No.

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| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>343 Brentwood</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4315 41st Street</u> | | | | d. STREET ADDRESS <u>4315 41st Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Case</u> Last <u>Whiton</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 13, 1877</u> | |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Connecticut</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Alfred C. Case</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Abigail Hoskins</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMY, NAVY, OR AIR FORCE? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service) <u> </u> | | | | 16. SOCIAL SECURITY NO. <u>?</u> | | | |
| 17. INFORMANT <u>Mr. Tudor Whiton</u> | | | | Address <u>7109 Wells Parkway Hyattsville</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | | | | |
| 21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>28 February</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Leon L. Gallin M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>7206 Colesville Road W. Hyattsville, Maryland</u> | | | |
| DATE SIGNED <u>3-20-59</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>LEON L. GALLIN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3-21-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Heuber's Sons</u> | | | | ADDRESS <u>1236 Ave M</u> | | | |
| 24a. REC'D BY REGISTRAR <u>MAR 24 59</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | | |

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3408 CERTIFICATE OF DEATH

03498

Reg. Dist. No.

| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
College Park, Md. | | | | c. LENGTH OF STAY IN 1b
4 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4801 Osage Street | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Anna Frances Wiggin | | | | 4. DATE OF DEATH
Month March Day 10 Year 19 59- | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 16, 1882 | |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | 11. BIRTHPLACE (State or foreign country)
Minnesota | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | | | | | |
| 13. FATHER'S NAME
? Aubrecht | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Gladys A Wiggin Address College Park, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Ventricular Fibrillation
DUE TO (b) Coronary Artery Heart Disease
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from 5-1 , 19 52 to 3-10 , 19 59 , that I last saw the deceased alive on June 10, 1959 , and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Aaron Dente | | | | DATE SIGNED 3-12-59 | | | |
| PHYSICIAN'S NAME (Type) AARON DENTE M.D. | | | | M.D. Hyattsville | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Entombment | | 22b. DATE THEREOF
3/13/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 22d. LOCATION (City, town, or county) (State)
Colmar Manor Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
F. Gasch's Sons | | | | ADDRESS 4739 Balto. Ave. Hyattsville, Md. | | 24a. REC'D BY REGISTRAR
DA 16 59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3467

CERTIFICATE OF DEATH

Reg. Dist. No.

03499

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly
c. LENGTH OF STAY IN 1b
6 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Bowie
d. STREET ADDRESS
Bowie Race Track.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Leroy Mundy Wilson | | 4. DATE OF DEATH
Month March Day 21 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/2/28 |
| 9. AGE (In years last birthday)
30 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Trainer | 11. BIRTHPLACE (State or foreign country)
Michigan |
| 12. CITIZEN OF WHAT COUNTRY?
United States | | 13. FATHER'S NAME
Archie Wilson | |
| 14. MOTHER'S MAIDEN NAME
Ozella | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Archie Wilson Address Detroit Mich
3884 14th. St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 490x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uses one pulmonary embolism
(c) lobar pneumonia bilateral | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 15 , 19 59 to March 21 , 19 59 that I last saw the deceased alive on March 21 , 19 59 , and that death occurred at 8:45A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Colburn Hall M.D. Rem dore 3/21/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3-26-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
West Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Detroit Mich | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Johnson, 1700 Druid Hill Ave. | | 24. REGISTRAR'S SIGNATURE
Charles S. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3468 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03500

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly | c. LENGTH OF STAY IN 1b
D.O.A. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rogers Heights | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Prince Georges General Hospital | | e. STREET ADDRESS
5203 56th Avenue | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Wilfred John Wilson | | 4. DATE OF DEATH
Month March Day 9 Year 19 59 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-28-09 |
| 9. AGE (In years last birthday)
49 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Construction superintendent U.S.Gov't. | | 12. KIND OF BUSINESS OR INDUSTRY
Canada | |
| 13. BIRTHPLACE (State or foreign country)
U.S.A. | | 14. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 15. FATHER'S NAME
Jules Wilson | | 16. MOTHER'S MAIDEN NAME
Rose Paitry | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes 1945-48 | | 18. SOCIAL SECURITY NO.
095-10-6021 | |
| 19. INFORMANT
Ruth Wilson; same address as # 2. | | Address | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage and shock
976x DUE TO
Conditions, if any, which gave rise to immediate cause (b) Shotgun wound of left arm.
(c), stating the underlying cause lost. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Self inflicted shotgun wound. | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 3-9-1959 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Fields | 20f. (City or town) (County) (State)
Edmonston, Pr. Geo. Md. |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John T. Maloney M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John T. Maloney, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
3/12/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State)
Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
L. Gasch's Sons | | ADDRESS
Hyattsville Md. | |
| 24a. REC'D BY REGISTRAR
MAR 11 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|----------------------------|--|
| Name of Deceased | | John P. Salvey, Jr. | |
| Sex | | Male | |
| Age | | 34-35 | |
| Date of Birth | | March 10, 1900 | |
| Place of Birth | | Dallas, Texas | |
| Usual Residence | | Dallas, Texas | |
| Cause of Death | | Shot wound, self-inflicted | |
| Place of Death | | Dallas, Texas | |
| Date of Death | | March 10, 1934 | |
| Time of Death | | 11:00 A.M. | |
| Occupation | | None | |
| Manner of Death | | Suicide | |
| Signature of Examiner | | [Signature] | |
| Signature of Coroner | | [Signature] | |
| Signature of Physician | | [Signature] | |
| Signature of Medical Examiner | | [Signature] | |